



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the investigation
into the quality, safety and
governance of the care
provided by the Adelaide
and Meath Hospital, Dublin
incorporating the National
Children's Hospital (AMNCH)
for patients who require acute
admission

8 May 2012

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority established to drive continuous improvement in Ireland's health and social care services.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Social Services Inspectorate – Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services

Monitoring Healthcare Quality – Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment – Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information – Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services

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Executive Summary

1 Introduction and background

This Report presents the findings of the Health Information and Quality Authority's (the Authority) investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the Hospital) for patients who require acute admission.

Since 2009, the Authority has had extensive engagement with the Hospital due to concerns raised in relation to risks to the health and welfare of patients associated with a number of aspects of the systems of care provided to patients at the Hospital and, in particular, the clinical risks to patients who required acute admission being accommodated on the corridor adjacent to the Emergency Department (ED) while awaiting transfer to an inpatient bed at the Hospital. However, despite a number of actions having been taken by the Hospital, the Authority was not assured that the immediate clinical, health and welfare risks to patients being cared for on the corridor adjacent to the ED were being adequately controlled and managed by the Hospital.

In June 2011, the Authority received the report of the Hospital's internal review into the unexpected death of a patient in March 2011. The patient had been receiving care, initially in the ED, and subsequently on the corridor adjacent to the ED while awaiting admission to an inpatient bed. The Authority was concerned that the report of this review did not indicate that the Hospital was effectively identifying and managing the clinical, health and welfare risks to patients requiring acute admission to the Hospital despite the history of engagement with the Authority highlighting these risks.

On 24 June 2011, the Board of the Authority considered these risks, and the degree of assurances that had been provided by the Hospital, and took the decision to instigate an investigation into the quality, safety and governance of the care provided to patients who required acute admission to the Hospital. The investigation focused on the time period from 2010 to 2011 which included the latter part of the term of the Board that was in place at the commencement of the investigation.

In carrying out the investigation, the Authority looked in detail at the quality, safety and governance of the system of care in place for patients requiring both unscheduled (unplanned, emergency care) and scheduled (elective and planned) care in the Hospital and, in particular, those patients admitted through the Emergency Department.

The Authority also investigated the effectiveness of the Board of the Hospital and the corporate and clinical governance arrangements that it had in place to assure itself that risks to patients were being appropriately managed by the Hospital – particularly the risks to patients receiving care in the ED and requiring acute admission. In addition, the Authority investigated the effectiveness of the planning, accountability and oversight arrangements that were in place between the Health Service Executive (HSE) and the Hospital, as a service provider in receipt of State funds, with a focus on how the HSE held the Hospital to account for the quality and safety of the services that it was providing.

In addition, the Authority felt that it was important to consider the national context for patients receiving similar services across the country in order to compare the performance of the ED service in the Hospital with other hospitals in the same period and to inform national learning for the purposes of improving the quality and safety of care for these patients. Consequently, the HSE provided data for a 24-hour period on 23-24 August 2011 for all service providers in receipt of State funds providing emergency department services in the State.

At the commencement of the investigation, the Authority was contacted directly by individual members of the public who had received care themselves or had accompanied family members who had received care at the Hospital. Even though this represented a small sample of the experience of patients who received care at the Hospital, their accounts demonstrated the impact of the service from these patients' perspectives. Whilst the majority reported that staff were caring, their accounts highlighted the reality of long waiting times to be seen by a doctor, lack of communication and the indignity of being accommodated for long periods of time on a public access corridor.

2 Profile of the Hospital

The Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH), was established as an entity on 1 August 1996 by order of the Minister for Health in accordance with section 76 of the Health Act 1970 by means of an Order and the amendment of an existing Charter. The Hospital provided services, pursuant to Section 38 of the Health Act 2004, on behalf of the HSE.

The Charter provided that all the powers of the Hospital are vested in and exercisable by a 23-member Hospital Board. The general function of the Board was to manage the activities of the Hospital and the services provided by it.

The Hospital is an acute general hospital situated in a rapidly growing urbanised area with a predominately young population, providing services for un-differentiated patients (all types of patients with any degree of seriousness or severity). The hospital has 615 beds which includes adult and children's beds. It provides elective and emergency adult and children's services on an inpatient, day case and outpatient basis.

3 Summary of findings

3.1 Unscheduled care

The adult emergency services at the Hospital provided services 24 hours a day, seven days a week for un-differentiated patients with acute and urgent illnesses or injuries. The patient referral pathway to the ED of the Hospital was considered to be similar to those of other hospitals in Ireland with a similar profile and with the majority of patients being self-referrals. The lack of an out-of-hours general practitioner (GP) service or primary care service in the area meant that patients and/or their GPs may have felt that they had no other option but to attend or refer the patient to the Hospital's ED to accelerate their treatment.

Whilst the patient was in the ED they were under the care of the emergency medicine consultant. However, at the commencement of the investigation, effective arrangements were not in place at the Hospital to ensure the seamless transfer of clinical responsibility for a patient from their clinical assessment in the ED, to their clinical assessment by the relevant speciality Hospital team through to their admission to a Hospital ward. This raised a significant concern about the Hospital's ability to ensure that patients, at all times, had a designated consultant who was clinically responsible and accountable for their care. This deficit was subsequently addressed by the Hospital in November 2011.

Of the total number of patients who attended the ED at the Hospital for the first six months of 2011, 14% left without completing their care. Recording the number of patients who leave the ED without completing their treatment, and the number of patients who re-attend the ED with the same clinical condition within seven days, are internationally recognised patient quality indicators for ED services. The Authority was not provided with information that the Hospital had effective systems in place to monitor and manage these patient indicators. In identifying this shortfall, the Authority highlighted the requirement for the HSE to set national key performance indicators which should be publicly reported and used to comparably benchmark EDs with a similar casemix.

The mean waiting time in the ED for a non-admitted patient at the Hospital from January to August 2011 was within the spectrum of 6 –7 hours and the Authority found that some patients were waiting within the ED for up to 61 hours before being discharged. However, unscheduled patients who attended the ED, and subsequently required inpatient admission whilst awaiting transfer to an inpatient bed, were accommodated either within a designated area within the ED or on the corridor adjacent to the ED. Over 80% of the admitted patients were accommodated on the corridor adjacent to the ED and waited, on average, a further 13 hours for an inpatient bed, with the longest waiting reported as 140 hours. This was an unacceptable situation for patients.

The Authority found a number of serious issues specific to the use of the corridor adjacent to the ED as a waiting area for admitted patients awaiting an inpatient bed. These issues had the potential to compromise the quality and safety of care for these patients and the capacity of the ED staff to provide a timely assessment of newly arriving patients in the ED. Following an unannounced inspection by the Investigation Team on 24 August 2011 which highlighted these risks, the Chief Executive of the Hospital confirmed that the use of the corridor adjacent to the ED ceased on 29 August 2011. The cultural belief by individuals in any hospital that the routine practice of accommodating patients on trolleys in corridors is acceptable should not be tolerated. This is not satisfactory for patients and the public and should cease.

3.2 Emergency services from a national perspective

Waiting times for patients in Ireland's emergency departments has been a longstanding concern from a patient safety and quality perspective. From a national viewpoint, the Authority compared the performance of EDs across the country for the same 24-hour period on 23-24 August 2011 and, through the data provided by the HSE, found that patients attending the majority of EDs in Ireland experienced waiting times of greater than six hours, with the longest waiting times of up to 115 hours for discharge and 137 hours for admission.

In addition, the Authority found inconsistencies in the level and quality of data that was provided by the HSE in relation to the 33 public hospitals delivering emergency care, and the adequacy of the information gathering and analysis processes in place to performance manage EDs from a patient experience and timeliness perspective.

These findings are serious issues of quality of care and patient safety and raise serious concerns in relation to how these services are currently being managed. The HSE has identified national initiatives, including the Clinical Care Programmes (particularly those in relation to acute medicine and emergency medicine services) which should contribute to solutions to improve key points of the patient journey. However, it is imperative that the HSE nationally, and the Special Delivery Unit (SDU), ensure that there is a nationally integrated programme-managed approach to the implementation of the HSE Clinical Care Programmes across the country, and at local hospital level, which is effectively led, governed, managed and monitored in order for such initiatives to bring about the improvements required.

3.3 Scheduled care

The Authority found that work was ongoing in the Hospital to improve the Outpatient Department (OPD) services, as a result of the recommendations of the Hayes Report.

The Authority found that the resource capacity for the radiology services was under pressure to efficiently respond to the demand from unscheduled, scheduled, OPD and community care services. The Hospital had contracted a third-party provider to reduce the waiting time for ultrasound scans. However, it was reported to the Authority that some patients were waiting long periods for imaging tests. For example, it was reported that OPD patients could be waiting up to nine months for a computed tomography (CT) scan or a magnetic resonance imaging (MRI) scan. The Authority concluded that the extended waiting times for reporting, for both inpatient and outpatient diagnostic imaging tests, required further review and improvement.

Timely access to diagnostics is a requirement of all safe, efficient and effective health services. In the context of providing timely access for patients, and managing resources in the most efficient way, the Authority considers that access to certain types of high demand, low capacity diagnostic imaging should be considered from a regional and national perspective. This arrangement should be developed, managed and coordinated as a shared resource across all hospitals and primary care – particularly for patients waiting for long periods.

At the time of the investigation, an Outpatient Turnaround Project was in progress at the Hospital which included addressing the issue of OPD waiting lists. In June 2011, 52% of all patients were waiting beyond 90 days to be seen in the OPD by a specialist team. Excessive waiting times for outpatient appointments can result in GPs referring patients, or patients self-referring, through alternative pathways in order to access care – including patients being referred or self-referring themselves to the ED.

The Hospital had exceeded the national overall figure for day case patients waiting less than six months and was in line with other hospitals in relation to patients waiting less than six months for elective admission and same day admission. The Authority found that the Hospital was outside the national average of 5.9 days for the average length of patient stay.

The length of a patient's stay can be safely and significantly reduced by hospitals ensuring that structured early morning ward rounds by senior clinical decision makers are undertaken. The Authority found that proactive patient discharge planning, to include early morning ward rounds, use of estimated date of discharge and timely patient discharge planning were not consistently supported by the range of clinical disciplines in the Hospital. In addition, the Authority found that the historic lack of an integrated approach to patient admission and discharge planning had contributed to challenges at the Hospital with the timely discharge of patients.

In June 2011, 69% of scheduled patients at the Hospital were waiting less than six months for an inpatient appointment. Nationally, at the time of the investigation, no hospital's waiting times for inpatient waiting lists had been published. This is of concern to the Authority and it recommends that these figures are nationally published and that all service providers should, as a priority, ensure that they have the appropriate arrangements in place to formally review and prioritise patient waiting lists in a structured manner.

It is crucial that elective surgery and scheduled diagnostic and therapeutic access for patients is managed, protected and that waiting times are informed, based on patients' needs. If it is not, it is of concern that patients may be at risk and perceive they have no other option but to seek alternative means of accessing healthcare. It is imperative that hospitals, the HSE and SDU implement and monitor efficiency strategies to actively manage timely patient access to scheduled and unscheduled care.

Older persons are the largest consumer of healthcare services in Ireland. Consequently, it is imperative that the system and arrangements at hospital and community level are appropriately organised to respond to their needs. The Hospital reported a monthly average of 63 patients over 65 years of age awaiting discharge to a step-down, rehabilitation or long-term care placement facility. Notwithstanding the efforts to enhance these processes at a local level, the Authority found that a more focused regional and national response is also required, for example, in the context of timely access to diagnostic and therapeutic services, to community intervention services and intermediate/short-term step-down support, rehabilitation and respite facilities.

3.4 Leadership, governance and management

3.4.1 Board Governance

The Authority found that the Board of the Hospital did not have effective arrangements in place to adequately direct and govern the Hospital nor did it function in an effective way. The Charter was not in line with modern corporate governance principles. The amalgamated organisation, into which three separate hospitals were merged in 1996, continued to embrace a number of different legacy beliefs, activities and cultures, lacked an organisation-wide strategic vision and culture and failed to adequately respond to the significant changes in healthcare delivery and advances in modern corporate governance. The collective membership of the Board did not reflect the relevant diversity of knowledge, skills and competencies required to carry out the full range of oversight responsibilities necessary for the Hospital at this juncture. Nor was the appointment process in line with modern governance principles.

The Charter provided for the establishment of a number of committees which were required to report to the Board in relation to their activities. These committees included clinical governance, resource and audit. In 2009, the Board commissioned an external review of the governance arrangements in the Hospital. As a result of this review, a Transitional Board of Management, which was a sub-committee of the main Board of the Hospital, was established in 2010 to manage the activities of the Hospital.

These Board committees, with the exception of the Transitional Board of Management, had no executive powers but rather advised, reported to and made recommendations to the Board. The Authority found little information as to how the Board, or any of its committees, oversaw and sufficiently assured themselves that the Hospital was delivering services in line with the service plan agreed with the HSE as articulated in the Section 38 Service Agreement for the resources provided. In addition, during the course of the investigation, information came to the attention of the Authority that raised concerns about the effectiveness of the governance arrangements in place for financial management, financial transparency and commitment control. In particular, the Authority was concerned that the Hospital did not have the internal controls in place to ensure its compliance with public procurement legislation.

In October 2011, the Authority had significant concerns in relation to the corporate and clinical governance arrangements in place at the Hospital and, in particular, the effectiveness of the Board's governance arrangements. The Authority met with the Minister for Health to advise of these concerns and subsequently issued preliminary draft recommendations to the Minister to help mitigate the risks at that time. The Hospital also had substantial financial difficulties with a significant budgetary overrun at that time.

On 9 November 2011, the Minister for Health, and the Church of Ireland Archbishop of Dublin, announced a series of new initiatives to reform and modernise the governance structures of the Hospital over two phases. The first phase was a further reduction in the size of the Hospital Board occurring through the appointment of an interim Board and, in the longer term, the Charter was to be replaced. The first meeting of the new interim Board of the Hospital took place on 21 December 2011 with new members of the Board being nominated with consideration of their competencies to undertake the role.

3.4.2 Executive Management

The Executive management arrangements at the Hospital had, over the last three years, gone through a number of significant changes with four members of staff acting in the role of Chief Executive. There was no clear scheme of delegation from the Board to the Chief Executive or to the Executive Management Team for delegating accountability in relation to the delivery and performance of the Hospital's functions.

It was of concern to the Authority that there was a reported ambiguity as to who had overall executive accountability for the quality and safety of the services delivered, and an apparent lack of integration across the corporate and clinical governance arrangements that were in place. The effective management arrangements that were needed to facilitate the delivery of high quality, safe and reliable care and support, by allocating the necessary resources through informed decisions and actions, were not sufficiently in place.

At the time of the investigation, the Authority found that historically, there was evidence that the Hospital had not adequately planned or controlled the scope or expansion of the clinical services provided. However, there was evidence that the Hospital was developing programmes for improvement including policies and programmes to deliver improvement in OPD turnaround times, bed management and patient discharge planning.

The turnover of senior executives in the Hospital, and the ongoing 'acting' status of individuals in key positions, created challenges in leadership, management, stability, decision making, confidence and authority. This had the potential to impact on the ability of the Hospital to effectively address the quality, safety and financial challenges that it faced.

3.4.3 Planning, Accountability and Oversight Arrangements

At the time of the investigation, the Authority found that the accountability and oversight arrangements in place to govern the relationship between the HSE and the Hospital were not sufficiently effective. Similarly, the Service Arrangement was not sufficiently effective, or used by the HSE to its full potential, as a framework to seek the necessary assurances from the Hospital that the services that it was funded to provide, on behalf of the HSE, improved, promoted and protected the health and welfare of patients in the most efficient and effective manner possible.

In addition, it did not appear to the Authority that there was reconciliation between the funds available, the budgetary overspend, catchment areas, innovation and research, demand and capacity and the core business of delivering high quality safe care to patients.

There was no evidence available to the Authority to demonstrate a clear understanding of the collective roles and responsibilities of each statutory and non-statutory hospital's contribution to the overall delivery of the HSE's Dublin Mid Leinster service plan as part of the HSE's National Service Plan. The HSE did not describe a service model and there was no clear direction provided for the Hospital.

The Authority concluded that there was a multiplicity of factors present in the actual oversight arrangements between the HSE and the Hospital that may have contributed to the failures that led to weak governance, substantial and longstanding budgetary overrun and ultimately, care being persistently provided to patients in the corridor adjacent to the ED in the Hospital.

3.4.4 The National Perspective

In order to ensure that existing and future individual hospitals, or network of hospitals, are led and governed effectively in a way that reflects the requirements of good corporate and clinical governance, it is imperative that the composition, membership, competencies and focus of a Board are suitable for its purpose.

It is equally essential that the capacity and capability of leaders and senior managers in healthcare organisations, and the wider health system, have the core competencies and capabilities to successfully lead, manage and execute the challenges and requirements of running a healthcare organisation.

Given the substantial amount of public money that is entrusted to service providers that are in receipt of State funds, there should be a robust mechanism in place to oversee the recruitment, appointment, performance and replacement of Board members, chief executives and other executives of these service providers. In addition, there should be greater involvement in the performance management of the chairperson of a board by the State, and of the chief executive by the chairperson of the board and also by the State, to ensure that any service provider in receipt of State funds is providing good, safe services within the resources available.

To invest in our leaders and managers of the future, there should be clear managerial career progression pathways and training and development programmes established, for both clinical and non-clinical leaders and managers.

In a system that is facing considerable challenges, the effectiveness of the governance arrangements through which public funds are allocated, defined and performance managed is critical. This requires the establishment of a clearly defined 'Operating Framework' for the State that outlines the key elements of the effective governance and operation of a high quality, safe and reliable health and social care service which is optimally designed to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy.

Currently, there is no nationally deployed resource to support hospitals (and other health and social care organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development programmes to build capacity and capability within such organisations.

In addition, a Special Measures Framework should be established to actively address and act on circumstances in which substantial and persistent poor performance of the board and/or executive management of a service provider in receipt of State funds occurs. This Framework should contain the provisions for intervention orders where the Minister for Health believes that a hospital (or other designated service provider) is not performing one or more of its functions adequately or at all, or that there are significant failings in the way it is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene.

4 Conclusion

The findings of this investigation reflect a history of longstanding challenges in the leadership, governance, performance and management of the Hospital which were manifest in the persistent, and generally accepted, tolerance of a wholly unacceptable practice of patients lying on trolleys in corridors for long periods of time.

It also reflects a history of a Hospital providing care to a substantial number of the population, that was allowed to struggle on despite a number of substantial governance and management issues in relation to quality, safety, planning and budgetary management which were present over a number of years. Despite a number of attempts to address the governance of the Hospital, and a number of improvement reviews having been undertaken, sufficient action was not taken by the Hospital itself or the Health Service Executive to address these issues. This reflected a failure not only in the governance of the Hospital but also in the governance of the health system that should effectively hold a service provider in receipt of State funds to account in the performance, delivery and quality of the service it provides.

Every day there are patients who receive good, safe care at the Hospital and there are patients who could receive better and safer care at the Hospital. The staff whom the Investigation Team met were committed to providing good, safe care and to improving the services that the Hospital provides. Going into the future, the challenges for the Hospital will be to drive, inject and embed strong personcentred leadership throughout the Hospital, in order to establish and sustain a strong culture of patient safety where all individuals involved in the Hospital have the primary focus of providing good safe care for the community that they serve. And, in so doing, behaviours and practices that result in unacceptable care for patients are simply not tolerated and a culture of openness, transparency and driving continuous improvement is supported, actively managed and led into the organisation.

Since the investigation commenced, there have been significant changes and improvements in the Hospital which include the establishment of an interim Board (on the way to replacing the Charter) and establishing a modern and fit-forpurpose board that reflects good corporate and clinical governance, a changing leadership team that is taking initiative and driving change within the Hospital and tangible improvements in the system of care within the Emergency Department at the Hospital. These developments are referred to in Appendix 13 of the Report which has been submitted by the Hospital and outlines the progress reported by the Hospital since the investigation commenced.

This investigation is a seminal point in the journey to modernising the way we run our health system. The business of person-centred health care is far too important to be run, managed and governed in a way that does not reflect a high performance, high quality and high delivery mindset – from patient to policymaker.

Ignoring persistent poor performance and not having, or using, the levers and drivers in place locally and nationally to share good practice and to support and address poor performance is no longer acceptable in a modern day health system. This must change. The findings and recommendations from this investigation focus on the improvements required in the Hospital, those required in similar hospitals, the changes necessary to improve the provider/'commissioner' oversight and accountability relationship and, finally, the improvements necessary for effective governance of the health and social care system by the State.

5 Moving forward

This investigation includes recommendations for improvement that are specific to the Hospital and also apply nationally. The Hospital will be required to develop an implementation plan for the recommendations which should support the improvement programme currently in place at the Hospital. Other hospitals are also required to assess themselves against these recommendations and develop an implementation plan for improvement in order to meet them.

Specifically, in relation to the existing boards of service providers in receipt of State funds and the recommendations that relate to these boards assessing themselves against the relevant recommendations within the report, the Department of Health should establish a mechanism to review the assessment and arising action plans and consider the mechanism for modernising the constitutional basis and composition of such boards where applicable.

The HSE, as the 'commissioner' and provider of services, should monitor all hospitals in receipt of State funds against the implementation plans as part of the service arrangement and as part of its ongoing performance delivery reviews with each provider.

Following the approval by the Minister for Health of the *National Standards for Safer Better Healthcare*⁽⁵⁾, and the subsequent commencement of a monitoring programme against the Standards, the Authority will be monitoring service providers against the implementation of these recommendations as part of that process. These Standards will be the first step in the trajectory of a licensing system being established in the Irish healthcare system. The recommendations of this report are consistent with, and indicative of, the objectives of the above National Standards, the future healthcare licensing requirements in Ireland and the progress towards self-governed Trusts as outlined in the Programme for Government.

Given the significant system-wide governance recommendations outlined in this Report, it will be imperative that there is the necessary political commitment to their managed implementation in order to drive further improvements in the quality, safety and governance of the care provided in our health system. The Authority therefore recommends that the Minister for Health should establish, as a priority, an oversight committee in the Department of Health to ensure the implementation of the governance recommendations in this Report. The committee should report to the Minister and include international expertise in the area of governance and also patient representation.

Recommendations

Local recommendations that are specific to the Hospital are coloured in green, and national recommendations are coloured in blue.

Recommendations – Unscheduled Care

Emergency Department Services

1. The Hospital's operational and executive management structures, with the assistance of the National Emergency Medicine Programme (NEMP), should have the necessary arrangements in place to implement the NEMP. The executive must provide periodic assurances to the Board of the Hospital regarding the quality, safety and timeliness of unscheduled patient care delivered at the Hospital.
2. The Hospital should have effective arrangements in place to manage and monitor the utilisation of the Clinical Decision Unit in order to ensure that the length-of-stay timeline for patients is less than 24 hours.
3. Every hospital should cease the use of any inappropriate space (for example, a hospital corridor or a parking area for trolleys) to accommodate patients receiving clinical care.
4. All hospitals providing an emergency department service should undertake a periodic analysis of the types and profiles of patients who re-attend or leave without being seen and the underlying causes for re-attendance. Any potential improvements identified as a result should be implemented and evaluated. Using this data, the HSE should set national key performance indicators (KPIs). These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar casemix.
5. All hospitals providing emergency care must continually manage and review the effectiveness of the patient-streaming, patient discharge arrangements, access to diagnostic investigations and fast-tracking systems in place.
6. The working hours and availability of emergency medicine consultants and senior clinical decision makers should be reviewed and amended in line with the objectives and recommendations of the National Emergency Medicine Programme.
7. The Manchester Triage System must be implemented, managed and periodically evaluated to ensure that it is being applied effectively in all hospitals.
8. The National Early Warning Score (NEWS) should be implemented in all clinical areas providing inpatient care. An emergency department specific system of physiological monitoring and triggered responses comparable to the NEWS should be implemented.

9. The involvement of general practitioners nationally in emergency departments, currently a reality in only a minority of hospitals, should be further enhanced and established on a formalised basis in partnership with primary care in all acute hospitals providing 24/7 care.
10. The working hours and availability of consultants on call in other emergency service areas in acute hospitals, such as acute medical units, should also be reviewed and amended where necessary.

Clinical Governance

11. All hospitals must have the necessary arrangements in place to ensure that there is a named consultant clinically responsible and accountable for a patient's care at all points in the patient journey and throughout their hospital stay.
12. All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that on-call clinical teams are available to see patients in the emergency department.
13. The Health Service Executive should review the current national position of the expanded roles within nursing and allied health professionals and implement a plan to roll out a more extensive programme of expanded practitioners within the appropriate clinical settings and with the necessary clinical governance arrangements in place nationally and locally.

Managing Performance and Information

14. The total patient time spent in the emergency department should be less than six hours. This time should be measured from the time the patient arrives in the ED to the time of departure from the ED. These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar casemix
15. National data pertaining to the quality, safety and timeliness for patients in all hospitals providing emergency department services should be monitored and published at local, regional and national level.
16. The HSE, in conjunction with the Special Delivery Unit, should develop, monitor and publish a suite of composite quality, safety and access indicators measuring key points throughout the totality of unscheduled and scheduled patient care.
17. All hospitals in Ireland should monitor the implementation of the National Ambulance Patient Handover Time in line with the National Emergency Medicine Programme which requires 95% of patients being handed over from an ambulance crew to the emergency department staff in less than 20 minutes, and where this is not met, corrective action should be taken.

Recommendations – Scheduled Care

Managing the Patient Admission and Discharge Pathway

1. The Hospital must engage fully and effectively with the range of stakeholders, including general practitioners, in order to ensure the most effective referral process for patients. This should be monitored and evaluated on an ongoing basis.
2. The HSE nationally and the Special Delivery Unit must ensure that there is a nationally integrated programme-managed approach to the implementation of the Clinical Care Programmes and patient admission and discharge strategies across the country which is effectively led, governed, managed and monitored at national level. This process should provide active support to local service providers in order to ensure that the local implementation of each National Clinical Programme is managed as a single integrated and seamless improvement plan within a hospital and community and not as separate, fragmented and isolated initiatives that have the potential to result in competing priorities and resources.
3. All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that early morning ward rounds are undertaken by senior clinical decision makers and that these form part of the explicit responsibilities of each consultant. Wherever possible, to facilitate multidisciplinary interactions and timely ward rounds, patients should be accommodated in centralised areas aligned to their admitting speciality.
4. All hospitals in Ireland should ensure that active patient discharge planning management is in place to include each patient having an individual discharge care plan with an estimated date of discharge from hospital.
5. The Health Service Executive and the Department of Health must as a priority review the current arrangements to provide patient access to multidisciplinary rehabilitation, community support and intermediate- and long-term care for patients requiring residential services. An integrated approach should be implemented, involving all health and social care professionals, with identified critical decision making at key points and key performance indicators to ensure a timely and seamless transition for the admission to and discharge from the acute service.
6. All hospitals should consider, where appropriate, safe mechanisms for implementing nurse-led patient discharge processes with the appropriate supporting clinical governance arrangements.

Clinical Governance

7. All hospitals should have effective arrangements in place to ensure that all patient waiting lists are periodically reviewed by a senior clinical decision maker to ensure that the clinical priority and urgency for each patient is managed and subject to regular review. Arrangements should include two-way communication with the patient and their general practitioner.
8. Voice recognition and clinical alert software with a formalised process for critical alerts to GPs for abnormal patient imaging results must be put in place in all hospitals and monitored and evaluated on an ongoing basis.

Managing Performance and Information

9. The Hospital should ensure that all initiatives taken to improve the efficiency and effectiveness of the Outpatient Department's 'Did Not Attend' rate should be monitored to measure their impact, and to identify any areas where additional gains may be achieved.
10. The Hospital should formally review and validate the patient waiting list for diagnostic imaging on an ongoing basis and establish a prioritisation process with appropriate monitoring mechanisms.
11. An analysis of activity, demand and utilisation should be undertaken in each hospital providing diagnostic services with a view to extending opening hours to better meet the needs of patients.
12. Access to high demand, low capacity diagnostic imaging (for example, CT and MRI scans) should be reviewed at a regional and national level and the HSE nationally should develop, manage and coordinate access and waiting times for this type of imaging as a shared resource across all hospitals and primary care – particularly where there are long waiting times for patients.
13. Benchmarking and publication of outpatient department (OPD) appointment wait times across all hospitals at a national, regional, local and consultant level should be put in place.

Recommendations – Board Governance

Governance Arrangements of Boards

1. The Charter should be replaced by the necessary legislative means to establish a fit-for-purpose Board.
2. The current AMNCH Interim Board should be dissolved in the coming months, and, through a managed transition, a new substantive Board should be appointed.
3. The Department of Health should ensure that any required legislative amendments to the constitution of existing healthcare organisations in receipt of State funds take account of these recommendations.
4. All health and social care service providers in receipt of State funds should ensure their compliance with the *Code of Practice for the Governance of State Bodies*.
5. The chairpersons of all hospital boards (in the first instance) in receipt of State funds should be line managed by a nationally designated post-holder for the purpose of holding the chairperson and the board accountable for the provision of well governed and effectively managed services and in relation to the appointment, performance and termination of the chief executive (this post-holder may be, for example, the Director General of the new HSE structure, or equivalent).
6. All health and social care service providers in receipt of State funds should come under the remit of the Comptroller and Auditor General and should be compliant with all directives from the Departments of Finance and Public Expenditure and Reform (particularly in relation to finance, procurement and staffing).
7. A mechanism should be established through which Foundations, Trustees and other community stakeholders, can continue to be involved in the development of hospitals in a non-governing and non-managerial way.
8. The establishment of boards of 'Hospital Groups/Networks' should be in accordance with the recommendations of this Report.

Board Structure and Composition

- 9.** Boards should be of a sufficient size (up to a maximum of 12) and expertise to effectively govern the organisation. The board should be selected and appointed through an independent process established by the State and on the basis of having the necessary skills, experience and competencies required to fulfil the role effectively. The board should comprise non-executive directors and a chairperson and, in keeping with good governance, individuals with conflicts of interest, including employees of the hospital and those with other relevant conflicts of interest, should not be appointed to the board. The chief executive, and other designated executive officers (to include as a minimum, the equivalent of the director of finance, medical/lead clinical director and director of nursing) should be formally in attendance at the board with combined shared corporate accountability for the effective governance and management of the hospital.

In advance of such an independent process being established, the members of boards with the necessary knowledge, skills, competencies and experience should be appointed by the Minister for Health.

- 10.** The Minister for Health should consider introducing remuneration of members of boards of organisations that are in receipt of State funds. A stronger performance management of board members should be introduced with consideration of the capitation of remuneration based on a defined percentage of the remuneration allocated as a core fee and the remainder based on the assessment of a board member by the chairperson within a performance criteria that includes attendance and contribution.
- 11.** Existing boards should undertake an assessment of the composition, competency profile and potential conflicts of interest of board members and make the necessary changes required to ensure that the board is constituted appropriately and in accordance with modern day corporate governance of boards and the recommendations contained in this Report.
- 12.** Existing boards of hospitals should consider replacing current and future vacant board director positions by using the independent process established by the State.
- 13.** A mandatory board induction programme should be in place for all new board members, and executive directors, covering such topics as the role and responsibilities of a board member, the role and responsibilities of executives, corporate and clinical governance, financial oversight, ethics and business conduct and their roles and responsibilities in achieving board objectives specific to the organisation.
- 14.** There should be a mandatory ongoing development programme for board members, informed through the annual self-evaluation of the effectiveness of the board, covering topics such as emerging governance issues and practices, quality and safety and financial management as well as more detailed information on organisation-specific issues.

Conducting Business of Boards

- 15.** The role and functions of boards must be clearly defined and the board should:
- ensure that there is an effective management team in place
 - oversee the development of, approve, and monitor the implementation of the hospital's strategic plan
 - ensure that there is an effective code of governance in place that is subject to ongoing review
 - require the executives to provide concise, understandable and relevant information that demonstrates that the hospital is achieving its strategic objectives, effectively managing its available resources and providing good, safe care
 - challenge the executives of the hospital when it is not clear that the hospital is achieving its objectives, and hold executives accountable for performance
 - provide assurances to the public that the service is managing its resources to provide sustainable safe, effective person-centred care
 - oversee and approve the development of the hospital's quality, safety and risk management plan and regularly evaluate the hospital's risk register and risk management activities
 - monitor rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the hospital, and also inform action that may be required to improve outcomes for patients.
- 16.** Board members should understand:
- their fiduciary duties to act as members of the board of an organisation and not representatives of any group
 - their equal responsibility for the consequences of the board's decisions, actions or non-actions
 - the need to support and abide by decisions made by the board even if, as individuals, they did not participate in the decision or did not agree with the decision.
- 17.** There should be a register of interests in place in relation to individuals with potential and/or actual conflicts of interest, in accordance with the requirements of the Ethics in Public Office Act, that includes board members and employees of the hospital and those with other relevant conflicts of interest. This should be subject to no less than annual review by the chairperson and chief executive.

- 18.** There should be an effective process in place for board members to declare potential and/or actual conflicts of interest whilst conducting board business that would allow the chairperson and board secretary to consider for themselves if there were agenda items that might possibly present a conflict of interest for any member of the board. All potential and/or actual conflicts that arise and decisions in relation to them should be documented.
- 19.** Boards should oversee and support the building of strategic partnerships with other stakeholders, including community organisations, primary and secondary care providers, in order to achieve the organisational objectives and to ensure that the organisation does not operate in isolation of the national and local system for the delivery of care and support to its population.
- 20.** A board should have access to the appropriate information in order to fulfil its role of effectively governing the delivery of high quality, safe and reliable healthcare. This should include the development of a quality and safety assurance framework with key performance indicators (KPIs) to assure patient safety, patients' experience, access and financial management. Every board should use these KPIs and other quality and safety information to assure itself about the quality and safety of care being provided and publish this information.
- 21.** A clear scheme of delegation of accountability from the board to chief executive and executive directors should be in place. This should include unambiguous delegated executive accountability and responsibility for the quality and safety of patient care.
- 22.** The board should ensure that the scheme of delegation for critical decision-making, including financial thresholds and policy decisions, is clear and unambiguous and is subject to no less than annual review by the board.
- 23.** The business of boards in receipt of State funds should be conducted openly and transparently. All boards should hold the maximum amount of their board meetings in public by June 2013 including conducting an Annual General Meeting in public from 2013.
- 24.** Boards should carry out an annual self-evaluation of the board, chairperson and board members, board committees, board operations and implement any improvements identified.
- 25.** Boards should put in place arrangements to facilitate staff to raise concerns about the quality and safety of patient care, and to allow escalation of these concerns to the board for their consideration.
- 26.** Boards should have in place processes that allow them to consider information provided by external sources (including from patient advocates) in relation to the delivery of safe care to patients.

- 27.** The existing boards of healthcare organisations in receipt of State funds should review the effectiveness of the corporate and clinical governance and management arrangements in place in the organisation in order to satisfy themselves that they are consistent with these recommendations and develop and implement an action plan to meet them accordingly.
- 28.** The chairperson must be accountable for ensuring that there are annually agreed objectives in place for the chief executive that accurately reflects the realm of their accountability, responsibility and authority.
- 29.** The chairperson must be accountable for ensuring that there is an effective process in place to support, develop and manage the performance of the chief executive. This process should incorporate the views of the Director of Hospital Care (or other designated individual) and other key stakeholders and should be undertaken by an appropriate committee of the board. Where there are issues of poor performance, the chief executive should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.

Recommendations – Executive Management

1. All service providers must have clear accountability and performance management arrangements in place to achieve the delivery of high quality, safe and reliable healthcare
2. The Chief Executive, and the Executive Management Team, should ensure that the implementation of the organisation's strategy, and the operational running of the business, is specifically and effectively aligned to the delivery of good quality and safe care within the available resources. The relationships with stakeholders, engagement with the public, organisational structure, delegated roles and responsibilities, governance fora, output and outcome measures and the business content of meetings should all reflect this purpose.
3. The Chief Executive must be accountable for ensuring that there is an effective process in place to annually agree objectives that reflect the delegated accountabilities and responsibilities for executive directors, and all staff within the organisation in order to deliver high quality safe services to patients.
4. The Chief Executive must ensure that there is an effective performance management and development system in place to support, develop and manage the performance of the executive directors and all staff within the organisation. Where there are issues of poor performance, the member of staff should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.
5. As part of the establishment of 'Hospital Groups/Networks' from the current State funded hospitals, competent high performing chief executives and executive directors (including director of finance, medical/lead clinical director and director of nursing) with clear delegated accountability should be appointed.
6. The appointment of a chief executive of a service provider in receipt of State funds should be overseen by the board with the appropriate degree of involvement from the director of hospital care (or equivalent designated individual).
7. The chief executives of all hospitals (in the first instance) in receipt of State funds, should be line managed by the chairperson as their direct line manager and, in addition, by a nationally designated post-holder for the purpose of holding the chief executive accountable for the performance and delivery of the commissioned service (this may be, for example, the Director of Hospital Care of the new HSE structure, or equivalent).
8. There should be a clear career progression for leaders and managers – both in non-clinical and clinical areas, to ensure that individuals receive the appropriate vocational training and development and human factor skills required for a senior management role.

Recommendations – Planning, Accountability and Oversight

Planning

1. The Department of Health should develop a national plan defining what tertiary and quaternary specialist services should be provided at which facility across the country, or contractually by other jurisdictions, based on informed factors including population need, forecasted activity and geographical distribution. This should be determined and implemented in advance of the universal health insurance system.
2. A comprehensive analysis, rationalisation and re-organisation of the distribution and provision of the types, number and operational times of (specific types of) hospital services in the Dublin area should be undertaken by the Department of Health and the HSE. The analysis should be based on current and future forecasted population demographics, needs, demand, activity, resource requirements and service utilisation. The analysis should inform the development and implementation of a Dublin Regional Healthcare Services Plan in order to provide the optimum services required to best meet the needs of the population in the most effective and efficient way.
3. A population and policy-informed needs-based allocation for health services in Ireland, that reflects current and future demand and capacity, should be undertaken by the Department of Health. Such a model should recognise the need for research and innovation where appropriate and should inform the resource-base for the modernising of service configuration.

Accountability and Oversight

4. The Department of Health should establish an Operating Framework for the health and social care system that outlines the key elements for the effective operation of a high quality, safe and reliable health system which is optimally designed and held to account to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy. The core elements of this framework should include:
 - clarity of the types of services provided in different types of facilities
 - the process by which specialist services are identified, resourced, delivered and monitored
 - the basis of resource allocation for defined services and service providers and a provision for variation of services
 - clear principles outlining the provider and the commissioner roles, responsibilities and relationship
 - an effective and deliverable contractual arrangement between the provider and the commissioner.

- 5.** Structured quarterly and annual accountability reviews with the chairperson and chief executive of each healthcare provider in receipt of State funds (in the first instance hospital services) should be established through a defined mechanism involving, for example, the director of hospital services and the Chief Executive of the HSE, or the future Director General of the HSE.
- 6.** The Department of Health should ensure that a suite of national key performance indicators for hospitals that measure core aspects of the business and include quality and safety, patient experience, access to services and financial management are developed. These should be collated, monitored and managed by hospitals in receipt of State funds and reported publicly.
- 7.** The Department of Health should put in place a Special Measures Framework to actively address and act on circumstances in which substantial poor performance of the board and/or executive management of a hospital occur. This Framework should contain the provisions for intervention orders where the Minister for Health, or delegated individual or agency (for example the chief executive or future Director General of the HSE), believes that a hospital is not performing one or more of its functions adequately or at all, or that there are significant failings in the way the hospital is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene. In such circumstances, an intervention order should be made.
- 8.** A nationally deployed resource to support hospitals (and other healthcare organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management should be established. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development.
- 9.** The Minister for Health should, as a priority, establish an oversight committee in the Department of Health to ensure the implementation of the governance recommendations contained within this Report. The Committee should report to the Minister for Health and include international experts in the area of governance and also patient representation.

Part 1

Introduction, Methodology and Profile

1 Introduction

This Report presents the findings from the Health Information and Quality Authority's (the Authority) investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the Hospital), for patients who require acute admission.

Since 2009, the Authority has raised concerns with the Hospital in relation to risks to the health and welfare of patients associated with a number of aspects of the systems of care provided to patients. These included serious concerns relating to a backlog of unreported imaging examinations, unprocessed general practitioner (GP) patient referral letters and the risks to patients being accommodated on the corridor area adjacent to the Emergency Department (ED) while awaiting transfer to an inpatient bed at the Hospital.

This has resulted in extensive engagement by the Authority with the Hospital. Throughout this engagement the Authority sought assurances from the Hospital that any potential risks to the health and welfare of patients were being governed and managed effectively and that actions were being taken to mitigate them. As part of the engagement, the Authority established a formal performance monitoring process of the Hospital. This required the Hospital to develop and implement a governance and quality improvement plan aimed at strengthening the governance and management of all services in the Hospital. A further requirement of this process was that the Hospital was to inform the Authority of any serious patient safety events that occurred.

However, despite a number of actions having been put in place by the Hospital in relation to patients requiring acute admission, the Authority was not assured that the immediate risks to patients being cared for on the corridor adjacent to the ED were being adequately controlled and managed by the Hospital.

In April 2011, the Hospital's Acting Chief Executive advised the Authority of the unexpected death of a patient who was receiving care on the corridor area adjacent to the ED of the Hospital while awaiting admission to an inpatient ward and that an internal review of the management of the care of the patient was in progress.

As a result of the existing interactions with the Hospital, and following the review into the unexpected death of the patient in the ED, the Authority was not assured that the Hospital was effectively identifying and managing the risks to patients receiving unscheduled care in the Hospital.

At a meeting on 24 June 2011, the Board of the Authority duly considered the risks to the health and welfare to patients being cared for on the corridor adjacent to the ED and the degree of assurances provided by the Hospital. The Authority considered that there were reasonable grounds to believe that there was a potential serious risk to the health or welfare of a person or persons receiving those services, and the risk may have been the result of one or more acts, failure to act or negligence on the part of the Hospital.

In accordance with Section 9(1) of the Health Act 2007⁽¹⁾ as amended (the Act), and having formed the opinion required by subsection 9(1)(a) of the Act, the Board of the Authority made the decision to instigate an investigation into the quality, safety and governance of the care provided to patients who require acute admission to the Hospital.

In carrying out the investigation, the Authority looked in detail at the safety and quality of the system of care in place for patients requiring acute admission to the Hospital, in particular, those patients admitted through the Emergency Department, and the effectiveness of the Board of the Hospital and the Health Service Executive (HSE) in discharging their functions in order to be assured that these serious risks to patients were being appropriately managed. The investigation focused on the time period from 2010 to 2011 which included the latter part of the term of the Hospital Board in place at that time and the Transitional Board of Management.

In accordance with the Terms of Reference of the investigation and the Authority's general power to provide advice to the Minister for Health, and in the interest of wider service improvement, where the Authority believes there are national implications of the findings of the investigation, then recommendations with national applicability are made accordingly. Wherever such national recommendations are made, they are separate from the recommendations directly relating to the Hospital itself.

The Report is divided into four parts:

- **Part 1** outlines the Introduction and Background to the Investigation, Investigation Methodology and Hospital Profile;
- **Part 2** outlines how the Hospital provided the clinical services;
- **Part 3** outlines how the Board governed and held the Hospital's Executive to account for the quality and safety of the services delivered; the arrangements that the Hospital Executive had in place to executively manage the delivery of services and how the system, vis a vis the Health Service Executive (HSE) oversaw and held the Hospital to account.
- **Part 4** outlines the conclusions and the way forward.

Where the Authority has made recommendations for improvements, these are in coloured boxes at the end of each section of the Report. Local recommendations

that are specific to the Hospital are coloured in green, and national recommendations are coloured in blue. These recommendations are presented collectively in the Recommendations section at the start of this Report.

The Report is supported by a glossary of terms and a number of appendices to provide the reader with additional information. In addition, the report contains references that are identified by a superscript number in the body of the report and which are listed at the end of the report. A supplementary bibliography is also provided at the end of the report.

The Authority would like to thank the staff at the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital, staff within the HSE, patients who contacted the Authority and participated in the patient meetings, the Economic Social and Research Institute (ESRI), the Advisory Panel, external members of the Investigation Team and all of the staff of the Authority who contributed to this investigation.

1.1 Background

In April 2009, the Health Information and Quality Authority received information regarding a concern from a local general practitioner (GP) which suggested that there were unopened orthopaedic patient referral letters and a backlog of imaging reporting at the Hospital. At a meeting in June 2009, the Authority was informed by the former Chief Executive of the Hospital that this was a historic problem and, at that time, all X-rays were being reported. He advised that the reporting of the backlog of 4,000 X-rays would be completed by the end of July 2009.

A series of engagements between the Hospital and the Authority followed. In August 2009, the Authority met with the former Chief Executive and the Medical Director who provided verbal assurances that the backlog was being reduced. The Authority sought, on numerous occasions, written updates on the progress through the latter half of 2009. The Hospital did not provide the requested updates.

In addition, in September 2009, the Authority received information relating to the health and safety of patients in the Emergency Department (ED), in particular the use of the corridor adjacent to the ED to accommodate patients who were admitted and awaiting transfer to an inpatient bed. The Authority repeatedly sought assurances from the Hospital that these risks were being managed. The Hospital advised the Authority that reports would be forthcoming. In the interim, the Authority received notification that the then Chief Executive would be leaving the Hospital in December 2009.

In January 2010, the Authority met with the new Chief Executive designate. At this time, the Authority was informed that the Hospital had established that the scale of the backlog was much greater than previously indicated and the unreported X-ray films were in the region of 57,000. The Chief Executive

designate indicated that the HSE and the Department of Health had been advised. The Chief Executive designate advised that an action plan had been put in place to manage the backlog of unprocessed GP letters, in addition to eradicating the backlog of X-ray reporting, by the end of March 2010.

In relation to the ED, the Authority was informed that the Hospital had established an ED Taskforce in December 2009 to address the concerns relating to patients being accommodated on the corridor adjacent to ED. The Hospital was requested to provide the Authority with assurances that there were arrangements in place to effectively and efficiently manage the care and flow of patients safely, as well as measures to address issues of clinical risk for patients within the ED. The Authority requested a written report on progress.

However, in March 2010, a backlog of 34,752 radiological reports and unprocessed GP letters still existed. At that time, the Authority was informed that the Chief Executive of the HSE had instructed that a review *Tallaght Hospital Review: Report of the Review of Radiology Reporting and the management of GP referral letters at the Adelaide and Meath Hospital (Dublin). Incorporating the National Children's Hospital* be undertaken into the circumstances that led to, and the subsequent management by the Hospital of, delays in reporting radiological examinations at the Hospital during the years 2005 to 2009⁽²⁾. This review is subsequently referred to as the Hayes Report.

In relation to the ED, the Hospital advised the Authority that a health and safety assessment had been carried out by the Health and Safety Authority in April 2010, with an improvement notice issued, and that the Hospital's ED Taskforce was completing a process improvement project to improve the patient journey through the ED.

In March 2010, following receipt of the 2009 report, *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures*⁽³⁾ which was commissioned by the Board of the Hospital, the Hospital announced that a number of developments relating to the governance arrangements, including the reorganisation of the Board and senior management of the Hospital and the introduction of a number of new Directorates, were to be implemented.

In April 2010, the Authority established a formal performance monitoring process of the Hospital, as part of the ongoing engagement. This was in response to risks identified by the Authority that related to:

- ineffective governance arrangements
- an absence of a corporate overview of risk management and complaints
- risks to the health and welfare of patients who were accommodated in the corridor adjacent to the Emergency Department due to the non-availability of beds in the ward areas.

The formal performance monitoring process required the Hospital to develop and implement a governance and quality improvement plan aimed at strengthening the governance, management and clinical services in the Hospital. In addition, there was a requirement for the Hospital to inform the Authority of any serious patient safety events that occurred. The terms of engagement between the Authority and the Hospital involved regular performance monitoring meetings with the Hospital, chaired by the Authority.

These meetings were to assess:

- i) The Hospital's tangible evidence of achievement in progressing the implementation of the governance and quality improvement plan.
- ii) The HSE and Hospital's progress in addressing the backlog of reported imaging examinations and unprocessed GP patient referral letters, together with any other issues that may need to be discussed.

The Hayes Report of the review of radiology reporting and the management of GP referral letters at the Hospital was completed in September 2010.⁽²⁾ The HSE was responsible for monitoring of the implementation of the recommendations and actions, and published a progress report in March 2012. This is referred to in later sections of this Report.

In relation to the ED, the Hospital reported that a number of actions were being taken which were aimed at addressing the concerns. These included the incremental capping of the numbers of admitted patients boarded on the corridor adjacent to the ED, the introduction of a variety of patient-admission-avoidance initiatives and the integration of the patient admission and discharges processes at the Hospital. However, the Authority was not assured that the immediate risks to patients who had been admitted but who were being cared for on the corridor were being adequately controlled and managed by the Hospital. The Authority continued to seek assurances from the Hospital regarding this issue. In July 2010, the Authority received written confirmation from the Hospital that all immediate risks to patient safety across the organisation had been addressed.

However, in December 2010, the Authority received further information relating to ongoing concerns from emergency medicine clinicians regarding the management of risks to patients in the ED. The Authority was advised that the situation in the ED had not improved, with overcrowding in the ED impacting on the timeliness of patient triage and assessment. In addition, the Authority was advised that up to 50 patients were being regularly accommodated on the corridor adjacent to the ED awaiting transfer to an inpatient bed.

The Authority met the then Acting Chief Executive in January 2011 and was subsequently provided with an updated governance and quality improvement plan and the Hospital's 'ED Turnaround plan' in February 2011. The Authority continued to engage with the Hospital and the HSE, responsible for monitoring and managing the performance of the Hospital, in relation to its concerns about the risks to patients in the ED and adjacent corridor.

The Hospital reported that key performance indicators (KPIs) had been identified and initiatives were in place to closely monitor any risks.

However, the Authority was not assured that the immediate risks to patients being cared for on the corridor adjacent to the ED were being adequately controlled. While the Hospital had established a plan to address the issues in the ED, and established an organisation-wide working group to manage the issue, much of its proposed actions identified were medium- to long-term solutions.

During a further meeting in April 2011, the Acting Chief Executive advised the Authority of the unexpected death of a patient who was receiving care on the corridor area adjacent to the ED of the Hospital while awaiting admission to an inpatient ward and that an internal review of the management of the care of the patient was in progress.

The Authority wrote to the Acting Chief Executive of the Hospital, and the HSE, reiterating its concerns in relation to the risks to the health and welfare of patients accommodated in the corridor area adjacent to the ED and sought assurances from the Hospital as to how the risks to patients were being assessed and the immediate actions being taken to mitigate the risks.

At that time, the Authority requested the Hospital to provide a copy of the report of the internal review of the circumstances surrounding the death of the patient, and the implementation status of any improvement actions (including quality and safety measures) agreed subsequent to the review. The Authority also sought information as to how the Board of the Hospital was updated on these risks. The Authority escalated these risks to the HSE's National Director for Quality and Patient Safety, the relevant Regional Director of Operations in the HSE, and the Chief Medical Officer in the Department of Health. Three further requests to the Hospital for this information were made in writing by the Authority between 5 May and 3 June before a draft copy of the report of the internal review was received on 20 June 2011.

The Authority had significant concerns about the report of the review. The report was of a poor quality and it did not appear to the Authority to provide any assurances that the Hospital had the necessary arrangements in place to mitigate the risks to the health and welfare of patients being cared for on the corridor adjacent to the ED. It gave rise to serious concerns regarding the care provided to these types of patients. In addition, it did not contain any information as to how the Board was being updated on these risks. The degree of assurances provided by the Hospital, together with the poor quality of the review into the unexpected death of the patient in the ED, suggested to the Authority that the Hospital was not effectively identifying, governing and managing the risks to patients receiving care in the ED. Subsequent to the commencement of the investigation, the Hospital submitted, as part of the documentation requested by the Investigation Team, an interim report of a further review of the care provided to patients boarded on the corridor adjacent to the ED, undertaken at the request of the Acting Chief Executive at that time.

At a meeting on 24 June 2011, the Board of the Authority duly considered the risks to the health and welfare to patients being cared for on the corridor adjacent to the ED and the assurances provided by the Hospital. In light of the facts and circumstances, the Board of the Authority concluded that there were reasonable grounds to believe that there was a potential serious risk to the health or welfare of a person or persons requiring acute admission and receiving services in the Hospital, and that the risk may have been the result of any act, failure to act or negligence on the part of the Hospital and that the risk satisfied sections 9(1)(a) and (b) of the Act.⁽¹⁾

Therefore, in accordance with section 9(1), the Board of the Authority decided to instigate an investigation into the quality, safety and standards of the services at the Hospital. The investigation focused on the time period from 2010 to 2011 which covered the latter part of the term of the Hospital Board that was in place at the time of the commencement of the investigation.

Terms of Reference

1. The Authority will assess the quality, safety and governance of, and accountability for, services provided to patients that present to the Emergency Department in the Hospital and are awaiting admission to the Hospital's inpatient wards. Specific patient cases, where the Authority deems appropriate, will be incorporated in this assessment.
2. The Authority will assess the quality, safety, governance and timeliness of the system and process of care for patients requiring acute admission into the Hospital with a particular focus on the patient journey from initial assessment, through admission to discharge.
3. The Authority will assess the effectiveness of, and accountability for, the corporate and clinical governance arrangements in place within and between the Board, the Transitional Board and Executive of the Adelaide and Meath Hospital, incorporating the National Children's Hospital (the Hospital) in addressing the quality and safety of services provided to patients in the Hospital.
4. The Authority will assess how the Health Service Executive's regional and national governance arrangements are supporting and monitoring the provision of safe, quality services in the Hospital.
5. The investigation shall be carried out by the Authority in accordance with its statutory powers under Part 9 of the Health Act 2007 and in whatever manner and with whatever methodology the Authority believes is the most appropriate. The scope of the investigation will be limited to those aspects of safety and quality that the Authority considers are most relevant and material to the investigation.
6. If, in the course of the investigation, it becomes apparent that there are reasonable grounds to believe that there is a further or other serious risk to the health or welfare of any person receiving services, and that further investigation is necessary beyond the scope of these terms of reference, the Investigation Team may in the interests of investigating all relevant matters, and with the formal approval of the Authority, extend these terms to include such further investigation within their scope or recommend to the Authority and/or the Minister for Health, that a new investigation should be commenced as appropriate.
7. The Authority shall prepare a report which will be submitted to the Board of the Authority for approval and then published. This report shall outline the investigation, its findings, conclusions and any recommendations that the Authority sees fit to make. In the interests of wider service improvement, national recommendations may also be made where the Authority considers appropriate.
8. The investigation will be conducted by an Investigation Team appointed and authorised by the Authority in accordance with Part 9 of the Health Act 2007. The Team will carry out the investigation and may exercise such powers as it has, pursuant to Part 9 of the Health Act 2007, including rights of entry, its rights to inspect premises, records and/or documents and its rights to conduct interviews.

2 Methodology

This section summarises the methodology used by the Authority in conducting this investigation.

2.1 Overall approach

In keeping with the Authority's mission and corporate values, the Authority has aimed to ensure openness and transparency throughout the design, development and implementation of the investigation. In doing so, the Authority engaged with the Hospital early in the process of the investigation and a detailed *Guidance and Lines of Enquiry* ⁽⁴⁾ document was published and also provided to stakeholders, including individuals being interviewed.

The Authority developed the investigation approach based on the investigation's Terms of Reference agreed by the Board of the Authority. The investigation was conducted through review and evaluation of information gathered from the:

- Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the Hospital)
- HSE Dublin Mid Leinster Region
- HSE nationally.

The investigation encompassed the time period from 2010 to 2011.

To ensure the consistency and reliability of the investigation approach, the Authority put in place a series of quality assurance processes. These included:

- the investigation methodology and supporting quality controls were designed in line with the Terms of Reference of the investigation. These included (but were not limited to):
 - a single communication approach with the Hospital and the HSE
 - consistency in the design and development of the assessment methodology with internal peer review at various stages during the investigation design stage
 - consistency in having a single team of investigators
 - standardised interview format
 - standardised collection and recording of information.

- an Investigation Team and Advisory Panel were established based on the skills, knowledge, experience and competencies required to fulfil, and in line with, the Terms of Reference of the investigation
- interviewees were provided with a summary of the notes of the interview undertaken for the purpose of providing feedback in advance of concluding the findings of the investigation
- interested parties of the Hospital were provided with relevant excerpt(s) of the draft report of the investigation findings for the purpose of due process feedback in advance of finalising the investigation report
- the final investigation report was approved by the Board of the Authority in advance of publication.

2.2 The Investigation Team

The Minister for Health, with the approval of the Minister for Public Expenditure and Reform, approved the appointment of members of the Investigation Team as authorised persons to conduct the investigation, in accordance with Section 70(1)(b) of the Act.⁽¹⁾ The Investigation Team was selected based on the required knowledge, skills and competencies, and comprised of internal staff members of the Authority and external professionals with experience and expertise relevant to the investigation's Terms of Reference. The Investigation Team assisted the Authority in conducting the investigation according to current national and international expert opinion in relation to governance, emergency care, surgical care, acute care and person-centred care.

The membership of the Investigation Team is set out in Appendix 1.

2.3 The Advisory Panel

The Authority arranged for the provision of additional professional advice through the establishment of an Advisory Panel. The role of this Advisory Panel was to advise the Authority in order to ensure an alignment of the recommendations with national and international best practice and to take account of the national clinical care programmes. This panel comprised of representatives of the Royal College of Surgeons in Ireland, Royal College of Physicians of Ireland, Irish College of General Practitioners, National Emergency Medicine Programme of the HSE and professional nursing advice.

The membership of the Advisory Panel is set out in Appendix 2.

2.4 Lines of Enquiry

Lines of Enquiry were developed by the Authority to guide the investigation approach in order to fulfil the Terms of Reference in an open and transparent way. These were designed to provide the Investigation Team with a framework for

the selection and gathering of information. The Lines of Enquiry represent a series of criteria to assess the arrangements in place in relation to the quality, safety and governance of care provided at the Hospital for patients requiring acute admission. They reflect the Authority's draft *National Standards for Safer Better Healthcare*⁽⁵⁾, national and international best evidence, the findings of previous reviews and investigations carried out by the Authority^(6,7,8,9) and the recommendations of the *Report of the Commission on Patient Safety and Quality Assurance*.⁽¹⁰⁾

The Lines of Enquiry were framed around the draft *National Standards for Safer Better Healthcare*⁽⁵⁾ themes of quality, capacity and capability. These themes reflect the essential components of a high quality, safe healthcare service and encompass the required capacity and capability of the service provider to deliver such services.

The quality themes are:

- person-centred care
- effective care
- safe care.

The capacity and capability themes are:

- leadership, governance and management
- workforce
- use of resources
- use of information.

The Lines of Enquiry were developed in line with the Terms of Reference of the investigation and were provided to stakeholders, including interviewees, through the *Guidance and Lines of Enquiry* document.⁽⁴⁾ Further information on the investigation's Lines of Enquiry can be found on the Authority's website at <http://www.hiqa.ie/publications/tallaght-hospital-investigation-guidance-and-lines-enquiry>.

2.5 Patient experience

The Authority was contacted directly by 30 individual members of the public who had received care themselves or had accompanied family members who had received care at the Hospital.

The Authority analysed and categorised the information received under the following four themes:

- access to care
- clinical care received
- dignity and privacy
- information support.

In line with the Terms of Reference of the investigation, the Authority arranged meetings with 14 patients, families or members of the public who had provided information pertaining to one or more of the above four themes. These included 12 patients and/or their family members who had presented to the ED and had the experience of receiving, or accompanying a relative who had received unscheduled care at the Hospital and two members of a patient representative group. In addition, as part of the interview process, members of the Authority also met with two members who served as patient and community representatives on the Hospital's Patient Forum.

The aim of these meetings was not to look in detail at individual patient incidents, but to encourage patients and family members to describe, in their own words, their experiences of the care provided and their perspective of the service they received.

The Authority recognises that these experiences are not a consistently representative sample of all the patients who received care at the Hospital and that it does not represent a statistically significant sample of patients using the ED. However, the personal accounts of the experience of the patients and their family members who contacted the Authority is indicative of, and supported by, the findings of the investigation.

The experiences of the care provided to patients by the Hospital have been a valuable source of information to the Authority in this report and will contribute to the improvement of services for future patients.

2.6 Investigation findings

In line with the Terms of Reference, the investigation involved the review and evaluation of information derived from multiple sources including documentation and data, patient healthcare records, interviews, observation and inspection. The Authority, in making its findings, used a process of gathering and analysing multiple sources of information to ensure that a finding was informed by at least three separate sources of information. For example, a finding may be derived from any combination of interviews, documentation and data. This process, commonly known as triangulation, ensures that there are clear and supported links between findings made and conclusions reached by the Authority and the evidence on which they are based.

Accordingly, any reference in the body of this Report to any fact, or set of facts or circumstances found by the Authority, has been identified from one of the above mentioned sources of information, and cross-checked against at least two other sources of information tending to support the finding concerned. Such references are also to be taken as indication that there was no, or not sufficiently weighty or sound, contradicting information before the Authority in relation to the matter concerned.

2.7 Review of literature

The Authority conducted a review of national and international best practice, within the scope of the Terms of Reference, to inform the investigative process and to support the findings and recommendations that are made in this report.

2.8 Documentation and data

In accordance with Section 73 of the Act⁽¹⁾, the Authority issued formal documentation and validated data requirements to the Hospital, the Hospital Board and the HSE at regional and national level (Appendices 3 and 4). The documents and data obtained covered areas such as the:

- corporate and clinical governance structure and management arrangements
- patient activity data in relation to scheduled and unscheduled care (hospital and national data)
- risk management systems including reported adverse incidents
- management of patient complaints
- way information was used to manage the services
- workforce planning and staffing arrangements.

The Authority provided a timeframe of 10 working days for the return of documentation and data from the date which the information requests were issued.

The Economic and Social Research Institute (ESRI), with the consent of the Hospital, provided the Authority with Hospital In-Patient Enquiry (HIPE) data concerning discharge and diagnosis information for the Hospital. The Authority reviewed and evaluated this information in conjunction with information gathered from other sources to inform the investigation findings.

2.9 Interviews

In accordance with Section 73 of the Act,⁽¹⁾ the Authority obtained information through interview with various individuals including Hospital staff, members of the Hospital Board, members of staff in attendance at the Hospital Board meetings and HSE staff at regional and national level whose role involved aspects of the governance and quality and safety at the Hospital. The Authority also interviewed two members who served as patient and community representatives on the Hospital's Patient Forum.

To identify individuals for interview, the Authority wrote to the then Acting Chief Executive requesting the contact details of designated post holders who had specific clinical and/or managerial and governing roles at the Hospital, including members of the Hospital Board.

The Authority interviewed selected individuals using a framework of areas of exploration related to the Lines of Enquiry. The interviews were used to clarify issues that may have been identified during the Investigation Team's review of documentation and data, gather information generally, consider any further information that was provided and to inform the investigation findings.

All individuals who were interviewed were provided with a minimum of 10 days notification of interview. Where an individual was unavailable on the allocated day, alternative arrangements were put in place to facilitate an interview at a later date, where possible. At the point of notification, individuals were informed about the interview process which included the opportunity to be accompanied by a colleague or advisor and were provided with the *Guidance and Lines of Enquiry*⁽⁴⁾ document detailing the investigation approach and Lines of Enquiry.

Following the interview, individuals were provided with a copy of a summary note of their interview for their review and were invited to inform the Authority, within 10 working days, if they had any feedback in relation to their interview summary. A digital recording of the interview was also offered to those who wished to obtain this. A template was issued to facilitate the return of feedback and comments. Where commentary was received, it was considered by the Authority in the development of the investigation findings.

2.10 Observation and inspection

In order to obtain information about the environment and physical facilities for the delivery of safe, high quality care to patients, members of the Investigation Team inspected a number of the areas in the Hospital. This observation included the:

- emergency department (ED)
- corridor adjacent to the ED
- admission and discharge lounge
- inpatient short-stay ward.

In addition to the scheduled observation components of the investigation, an unannounced inspection of the ED, and the corridor adjacent to the ED, was undertaken by members of the Investigation Team on 24 August 2011 in accordance with section 73 of the Act.⁽¹⁾

2.11 Patient healthcare record review

To further inform the patient experience and understand the unscheduled care patient pathway, the Authority selected healthcare records for review, in accordance with section 73 of the Act,⁽¹⁾ of those patients who were admitted and awaiting transfer to an inpatient bed at the time of the unannounced visit on 24 August 2011.

2.12 Due process feedback

The Authority provided a copy of the relevant excerpt(s) of the confidential draft report of the investigation findings to a wide range of identified interested parties*, including those interviewed.

Those who received a copy of the relevant excerpt(s) were invited to offer their feedback and commentary generally on any matters in the draft report excerpt, as well as any further information that they considered pertinent to the investigation.

The Authority provided a timeframe of 21 days for the return of any feedback and comments from the date of issue of the draft excerpt of the report. Every comment received was carefully considered by the Authority prior to the publication of the Report.

* The former Finance Director of the Hospital was offered the opportunity to review and comment on certain sections of the draft Report prior to its publication, but was not in a position to do so due to illness.

3 Person-centred Care

3.1 Introduction

Person-centred care encompasses the behaviours, practices and procedures which ensure that the patient is at the centre of the delivery of coordinated and integrated care which, in turn, should ensure the best possible outcomes for the patient in terms of health and welfare. This care should always be delivered within a safe environment.

Effective systems and processes, and good communication by all involved in the care, should be in place to ensure the patient is fully informed throughout their episode of care and, as a result, is able to make informed choices and decisions. Dignity and privacy are fundamental to the delivery of person-centred care and lead to better patient experience and healthcare outcomes for patients.⁽⁵⁾

Service providers should regularly monitor and evaluate the quality, safety and timeliness of the services that they provide from the patients' perspective. Learning from complaints, claims, concerns and compliments plays an important role in promoting improvements in the safety and quality of patient care and should be an inherent component of a safety and learning culture throughout an organisation.⁽⁵⁾

The Investigation Team found the Hospital to be proactive in eliciting patient feedback and had conducted a number of patient satisfaction surveys throughout 2010 and 2011. These surveys were specific to specialist areas which included cardiology, ward areas, endoscopy, haematology and surgical services. To gain a wider perspective, in 2010 the Hospital participated in a national patient satisfaction survey, *Measuring the Patient's Experience of Hospital Services*,⁽¹¹⁾ undertaken by the Irish Society for Quality and Safety in Healthcare. The survey was based on the experience of 278 patients during their stay in the Hospital, 53% of whom were admitted via the emergency department. The key findings were as follows:

- 93% of those surveyed were satisfied overall with the service they received
- 94.1% reported that they were always treated with dignity and respect
- 97.8% of those surveyed found the healthcare team to be courteous
- 96.2% reported that they trusted the Hospital staff in charge of their care
- 95.1% of those surveyed were confident about the treatment they received.

Prior to and following the announcement of the investigation, the Authority was contacted, both in writing and by telephone, by 30 individual members of the public who had received care themselves, or who had accompanied family members who had received care at the Hospital during the timeframe covered by the investigation. The Authority analysed and categorised the information received from the 30 patients and/or their families under the following four themes:

- access to care
- clinical care received
- dignity and privacy
- information support.

The general themes arising out of this information were identified and the Authority met, in total, 14 patients, families or members of the public who had provided information that appeared illustrative of a theme, had been admitted to the Hospital through the ED, had been accommodated on the corridor adjacent to the ED, or for other reasons would inform the investigation.

The Authority also met with two representatives of an independent children's patient advocacy group, and two representatives of the Hospital's Patient Forum.

Each of the patients and families who met or corresponded with the Authority gave generously of their time. They recounted their stories in the hope that their experiences and contributions would lead to improvements for other patients.

3.2 Patient meetings

As outlined above, in order to explore the provision of patient-centred care from a patient's perspective specifically, the Authority met with 14 patients, families or members of the public. These included 12 patients and / or their family members who had presented to the ED and had the experience of receiving or accompanying a relative who had received unscheduled care at the Hospital.

The Authority recognises that this is a very limited sample of the experience of all the patients who received care at the Hospital and that it does not represent a statistically significant sample of patients using the ED. However, the aim of the patient meetings was to encourage patients and family members to describe, in their own words, their experience of the care provided and their perspective of the service received, and to inform the report. The patients and family members reported their personal experience. The following section of the Report provides an account of the unscheduled care pathway from a patient's perspective as described by individual patients and / or their family members at the patient meetings.

3.3 What the patients said

3.3.1 Access to Care

'Access' focussed on the patients' experience from the time that they were registered and triaged at the ED to the time they were seen by a doctor. The patients recounted different experiences. Some were taken directly to the ED assessment area and recounted minimal waiting times to be seen. However, others reported long delays to be initially assessed by the nurse and to be seen by a doctor. These patients described waiting in a very busy waiting area and some recounted having to return for long periods to the waiting area once they were seen by the triage nurse.

Some of these patients had lower limb injuries and reported that the waiting area lacked facilities for them to keep their injured leg elevated so as to prevent further injury or deterioration of the injury and that no one checked on patients while waiting to be seen.

3.3.2 Clinical Care Received

The majority of the patients said that most of the staff were caring and they also commented on how good individual nursing and medical staff were.

However, in relation to the organisational arrangements, some patients recounted how they were unsure who was in overall charge of the service and reported that they felt that insufficient attention was given to their own account of their medical history. Others reported that they felt that their care was disjointed with limited coordination of care between the different clinical disciplines.

One patient who attended the ED, and was subsequently admitted and transferred to the corridor adjacent to the ED, described their experience and how they felt vulnerable and unsafe while there.

3.3.3 Information and Support

The patients who remained in the waiting area for long periods reported that no updates or additional information were provided by the staff as to what would happen next or the expected waiting time. Some patients recounted that they were not aware of the clinical grade of doctors (consultant / registrar / senior house officer) who examined them.

3.3.4 Dignity and Privacy

Those patients who had been admitted and accommodated on the corridor adjacent to the ED described their experience as traumatic. Some reported that they were accommodated on this corridor for more than 24 hours. The corridor is the public access corridor for children attending the Paediatric Emergency Department at the Hospital. It was recounted to the Authority by the children's

patient advocacy group that some parents had reported that their children were upset by what they saw when they passed through the corridor adjacent to the ED on their way to the X-ray department. All the patients who the Authority met described the lack of dignity and privacy they experienced whilst on the corridor. One family member recounted how a clinical procedure was carried out on their relative in the corridor.

The Authority's investigation findings in relation to unscheduled care, including patients waiting for admission on the corridor adjacent to the ED, are described in Chapters 5 and 6.

3.4 Summary

The Authority recognises that these experiences are not a consistently representative sample of all the patients who received care at the Hospital and that it does not represent a statistically significant sample of patients using the ED. However, the patients' account of their experiences in the ED, and the corridor adjacent to the ED at the Hospital, demonstrated the impact of the service from these patients' perspective.

While the majority of this sample of patients reported that the staff were caring and recounted how good individual nursing and medical staff were, their account highlights the reality of long waiting times to be seen by a doctor, lack of communication and the indignity of being accommodated for long periods of time on a public access corridor while waiting for transfer to an inpatient ward. The experiences of the care provided to patients by the Hospital have been a valuable source of information to inform the work of the Authority, and will contribute to the improvement of services for future patients.

4 Profile of the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

4.1 Overview

The Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the Hospital), opened in June 1998. The amalgamation of the different hospitals joined together three distinct traditions and histories. The Boards of three Dublin hospitals: the Adelaide Hospital, the Meath Hospital, and the National Children's Hospital came to an agreement that the activities of each of these hospitals should be combined and carried out by a single organisation on a site at Tallaght, Dublin. However, these Boards requested that 'the letters patent of the 27th day of November, 1920 granting incorporation to the Adelaide Hospital, Dublin as amended by the Adelaide Hospital (Charter amendment) Order, 1980 be amended to enable this agreement'. Consequently, the Hospital entity was established on 1 August 1996 by order of the Minister for Health in accordance with Statutory Instrument No. 228/1996 The Health Act, 1970 (Section 76) (Adelaide and Meath Hospital Dublin Incorporating the National Children's Hospital) Order, 1996⁽¹²⁾. This order, together with the charter which it amended, was subsequently referred to as the Charter.⁽¹²⁾

Established under the Charter, the Hospital is the newest of the Dublin Academic Teaching Hospitals (DATHs). The Hospital is a public, voluntary, university teaching hospital (associated with Trinity College Dublin).

At the time of the commencement of the investigation, the Hospital was managed by a 23-member Board. The Board was constituted under the Charter that was created under the Statutory Instrument referred to above. Pursuant to the Charter, all the powers of the Hospital are vested in, and exercisable by, the Hospital Board. This Charter provided that there shall be a Board of Management of the Hospital and that the general function of the Board shall be to manage the activities of the Hospital and the services provided by it. The functions and powers described by the Charter may have been relevant in 1996. However, those described arrangements are not in line with the principles of modern corporate governance.⁽¹³⁾

The Board's Code of Governance, dated 2005, articulated its role and responsibility as being that the Board shall develop and review on a regular basis the mission, vision, objectives, functioning and strategic plan of the Board, establish, implement and evaluate a quality management system for the regular assessment and review of patient care and manage the property and finances of the Hospital.

At the time of the investigation, 2545 whole time equivalent (WTE) staff were employed in the Hospital which is situated in a rapidly growing urbanised area with a predominantly young population. The Hospital is one of a number of hospitals serving the people of Tallaght, Rathfarnham, Firhouse, Clondalkin, Templeogue, Terenure, West Wicklow and parts of County Kildare and South Dublin County, with a population of between approximately 450,000 to 500,000.

There are four primary care centres in the catchment area of Dublin South West/ Kildare/West Wicklow. There are 34 planned Primary Care Teams (PCT) for the area of which 20 teams were in place at the time of this Report. There were 134 General Medical Services (GMS) general practitioners (GPs) within the Hospital's catchment area, of which 58 were in Dublin South West and 26 in Kildare/West Wicklow. Of the 134, 120 were working within the Primary Care Teams, 23 in Dublin South West and 97 in Kildare/West Wicklow.

The Hospital is an acute general hospital providing services for un-differentiated (all types of patients with any degree of seriousness or severity) patients. The Hospital has 615 beds which includes adult and children's beds. It provides elective and emergency adult and children's services on an inpatient, day case and outpatient basis. The Hospital's clinical specialties include:

- Anaesthesia Paediatrics
- Anaesthesia Pain Management
- Anaesthesia Adults (including Intensive Care Unit)
- Cardiology
- Dermatology
- Emergency Medicine
- Endocrinology / Diabetes
- Gastroenterology
- General (Internal Medicine)
- Acute Care of the Older Person
- Medical Oncology
- Nephrology and Renal Dialysis
- Neurology
- Neurophysiology
- Palliative Medicine
- Rehabilitation Medicine
- Rheumatology
- Paediatric Community Child Health
- Paediatric Emergency Medicine
- Paediatric Endocrinology

- Paediatric Gastroenterology
- Paediatric Neurology
- Paediatric General Medicine
- Paediatric General Surgery
- Paediatric Respiratory Medicine
- Paediatric Orthopaedics
- Paediatric Ear Nose and Throat
- Paediatric Cardiology
- Pathology
- Child and Adolescent Psychiatry
- General Adult Psychiatry
- Liaison Psychiatry
- Older Person Psychiatry
- Radiology
- Gastrointestinal Surgery
- Gynaecology
- Ophthalmology
- Orthopaedics – Trauma and Elective
- Otolaryngology (ENT)
- Urology
- Vascular Surgery.

The Hospital provides a number of specialist services including:

- cystic fibrosis
- day-ward pre-assessment clinics
- falls
- nurse pre-assessment clinics
- nutrition and dietetics
- occupational therapy
- podiatry
- speech and language therapy
- musculoskeletal physiotherapy
- physiotherapy
- rapid access stroke prevention service
- tissue viability
- urodynamics
- wound management.

At the time of the investigation, the organisational structure described four specific Clinical Directorates. These were Peri-operative (which included general surgery), Medicine (which included adult emergency medicine), Diagnostics (diagnostic imaging, pharmacy and infection control) and Children's (which included paediatric emergency medicine). The Mental Health Directorate is a separate HSE service based at the Hospital. While children's services operated as a clinical directorate within the Hospital governance structure, the paediatric emergency department and paediatric elective services were managed independently from the adult services and have retained their own speciality-specific Matron and clinical staff.

The Clinical Directorates that the investigation focused primarily on were:

- Peri-operative
- Medicine (which included emergency medicine)
- Diagnostics.

4.2 Patient activity

Table 1 below gives an overall picture of the adult activity levels at the Hospital in relation to the total number of planned inpatient discharges, day case attendances, outpatient attendances, emergency department attendances and emergency admissions as was reported by the Hospital for 2010 and specified variable periods of 2011. This information demonstrates that the main source of inpatient admissions were unscheduled patient admissions through the Emergency Department (ED).

Table 1: Number of adult patient activity by elective inpatient discharges, by day case and Emergency Department attendances and number/percentage of Emergency Department admissions in 2010 and variable periods in 2011

Activity data	Volume by timeframe	Volume by timeframe
Adult elective inpatient discharges	2010	January to June 2011
Public	1,795	1,010
Private	807	375
Total	2,602	1,385
Activity data	Volume by timeframe	Volume by timeframe
Adult day case attendances	2010	January to August 2011
Public	19,716	14,319
Private	9175	6017
Total	28,891	20,336
Activity data	Volume by timeframe	Volume by timeframe
ED adult attendances	2010	January to June 2011
ED adult admissions	13,073	6,382
ED admission as a percentage of ED attendances	31%	31%
Total	41,534	20,522

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

The Authority's review of the 2010 HIPE data (see Table 2) found that the main conditions (known as principal diagnoses) for the overall hospital inpatient discharges at the Hospital were patients with: chest pain (unspecified) (n=816), pneumonia (unspecified) (n=379), ureteric calculus (n=280), syncope and collapse (n=247) and chronic obstructive pulmonary disease with acute lower respiratory infection (n=229).

Table 2: Principal diagnoses for overall inpatient discharges at the Hospital in 2008, 2009 and 2010

Principal diagnoses for overall hospital inpatient discharges	2008 Volume	2009 Volume	2010 Volume
Chest pain unspecified	653	484	816
Pneumonia unspecified	329	381	379
Ureteric Calculus	231	188	280
Syncope and collapse	196	154	247
Chronic obstructive pulmonary disease with acute lower respiratory infection	135	187	229
Atherosclerotic heart disease of native coronary artery	219	197	218
Urinary tract infection site not specified	175	186	201
Fracture of lower end of radius unspecified	124	177	200
Chronic obstructive pulmonary disease with acute exacerbation unspecified	227	166	194
Atrial fibrillation and flutter	166	174	183

Source HIPE data – patient numbers ranked by 2010 volumes

In comparison, on review of the Hospital's HIPE data for emergency admissions in 2010, the Authority found that the main conditions (principal diagnoses) were patients with: chest pain (unspecified) (n=790), pneumonia (unspecified) (n=361), syncope and collapse (n=236), chronic obstructive pulmonary disease with acute lower respiratory infection (n=222) and ureteric calculus (n=200). This is reflective of the emergency department as the main source of inpatient admissions.

Part 2

Clinical Services

5 Unscheduled Care

5.1 Introduction

Within this section, the Authority will describe the current developments to improve the management of patients requiring unscheduled care in Ireland and will then go on to outline the Authority's investigation findings in the provision of unscheduled care in the Hospital. This section will also set out the recommendations for improvement, both specifically in relation to the Hospital and nationally for the purpose of wider system learning.

Unscheduled care is defined as care for people who require, or who perceive the need for, advice, care, treatment or diagnosis that is not planned or pre-booked and is available everyday with a prompt response according to the urgency of the clinical need.⁽¹⁴⁾ Patients requiring unscheduled care can be admitted to a hospital through a variety of different pathways. For example, via the emergency department, the day oncology and surgical service, outpatients department, directly by referral from their general practitioner (GP) or through a patient care pathway, for example, a stroke care pathway. Examples of unscheduled patient care include patients with acute abdominal pain, haemorrhage, fractured leg, severe headache, intoxication from alcohol and / or drugs, pneumonia and chest pain.

It is important to note that the effectiveness with which a hospital manages patients who require unscheduled care and admission, is directly related to the effectiveness with which it manages patients who require admission for a booked or elective purpose – known as scheduled care (for example patients booked for planned surgical procedures). The patient admission and discharge processes are interdependent on each other. In a hospital with a fixed number of inpatient beds, these patient admission and discharge processes, and the behaviours of staff providing the care, must be actively and effectively managed by the hospital.^(15,16) If this does not happen there may be a significant risk to the quality, safety and timeliness of care for all patients. This may result in patient safety events occurring.

Both admissions processes are dependent on patients being assessed and cared for in the right place, by the right level of clinical decision maker daily, with prompt access to diagnostic results and for the optimum duration. The optimum duration involves elective patients only being admitted for the minimum safe period

required, patient discharge planning beginning on the day of admission to the hospital and the hospital actively designing systems to ensure a continual patient flow through the hospital to avoid patients being 'backed-up' in inappropriate areas with the resulting risks that may arise. This will be further discussed in Subsection 8.8.

The Emergency Department (ED) is often perceived as being the front door for patients who require emergency and acute care. The ED receives patients brought in by ambulance, referred directly by their GP and people who decide to go straight there themselves.

In 2011, the HSE's National Emergency Medicine Programme (NEMP) was established, with a plan to improve the safety and quality of care and reduce waiting times for patients in EDs throughout the country. This Programme is one of the HSE's 20 Clinical Care Programmes led by multidisciplinary clinical teams. The 20 Programmes are defining the ideal care for patients with a range of different conditions and in a variety of different services and settings that should be implemented across Ireland. Specifically, they are focusing on solutions which will improve patient care, remove waiting lists and enable a better use of resources.

At the time of the investigation, the National Acute Medicine Programme (NAMP)⁽¹⁷⁾ had been published. This Programme is concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within, hospital and require urgent or emergency care (see Subsection 5.12).

In addition, the Minister for Health established a Special Delivery Unit (SDU) in 2011 with the objective of improving patient flow through the public healthcare system, with an initial focus on the emergency department patient waiting times.

⁽¹⁴⁾ The SDU is working with key teams in the HSE and the National Treatment Purchase Fund (NTPF) and building on initiatives already underway including the National Clinical Care Programmes. The SDU has been established to provide a performance management function for the Irish hospital system with the aim of reducing patient waiting times.

The SDU's national priorities encompass reducing patient waiting times in:

- emergency departments
- access to inpatient services
- access to outpatient services
- access to diagnostic testing.

At the time of the investigation, the SDU had initiated High Intensity Supports aimed at reducing patient waiting times in the EDs of eight hospitals, which were the:

- Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital
- Mid-Western Regional Hospital Limerick
- Cork University Hospital
- Beaumont Hospital, Dublin
- Mater Misericordiae University Hospital, Dublin
- St Vincent's University Hospital and St Columcille's Hospital, Dublin
- Galway University Hospital
- Our Lady of Lourdes Hospital, Drogheda.

It is important that hospitals ensure there are no unintended undesirable consequences of the High Intensity Supports, for example, they should ensure that the problem of patients previously waiting inappropriately for extended periods in the ED, are not transferred to other parts of the service or that scheduled (planned) care is not continuously cancelled. Therefore, it is important that hospitals are supported by the HSE in managing these initiatives through the development, monitoring and publication of a suite of composite indicators that measure key points throughout the totality of the patient journey in order to achieve a coordinated and integrated approach to the quality, safety and accessibility of unscheduled and scheduled patient care.

At the time of the investigation, the Hospital had begun initial work with the clinical care programmes and the SDU towards reducing patient waiting times in the ED, implementing the NAMP⁽¹⁷⁾ and the recommendations of the draft National Emergency Medicine Programme (NEMP)⁽¹⁸⁾.

It was reported by the SDU that in 2012, additional national initiatives had begun or were due to commence which included the:

- appointment of a SDU Director of Performance Improvement in Unscheduled Care
- high intensity SDU support for 28 hospitals providing ED services
- approval for the procurement of a national ED clinical information system
- ongoing work between all hospitals, the SDU and Clinical Care Programmes to implement the National Emergency Medicine Programme
- national monitoring and reporting of ED patient waiting times.

Cognisant of the above initiatives, and in conjunction with international and national evidence and best practice guidelines, the Authority identified essential elements required to ensure a timely and safe quality service for patients attending an emergency department⁽¹⁸⁾. These essential elements are detailed in Table 3.

Table 3: The essential elements required to ensure a timely and safe quality service for patients attending an ED

Access and timeliness of care

- senior clinical decision makers in emergency medicine on-site at all times
- timely and full handover of a patient from an ambulance crew to the Emergency Department staff
- patient registration before or at the same time as triage
- patient's clinical assessment completed with a decision to admit or discharge the patient within six hours of their attendance at the ED
- timely access to, and reporting of, diagnostic patient tests
- minor injury care pathway in place
- patient streaming and fast-tracking systems for specific patient groups and conditions implemented where appropriate
- condition-specific or inter-specialty care pathways in place and regularly audited.

Supporting policies, procedures and structures

- standardised minimum data set in place for patient registration
- hospital protocols for patient handover and referral, supported by audit and staff training
- implementation of the Manchester Triage System, to include direct pain assessment
- advanced triage protocols in place
- National Early Warning Score (NEWS) in place.

Multidisciplinary Approach

- implementation of multi-professional and multidisciplinary patient care algorithms, clinical guidelines and care pathways which are regularly audited across a wide range of patient conditions and/or patient presentations
- a full range of access to therapy professions and social workers available for patients within the ED.⁽¹⁸⁾

5.2 Emergency Department

The adult emergency services at the Hospital provide services 24 hours a day, seven days a week for un-differentiated patients (all types of patients with any degree of seriousness or severity) with acute and urgent illnesses or injuries. Over the period of January to June 2011, approximately 85% of all admissions onto the wards at the Hospital were patients requiring unscheduled admissions.

The ED at the Hospital has a large adult waiting area with direct access to the resuscitation room for emergency admissions. The reception and patient registration office is located adjacent to the waiting area. The Adult ED is adjacent to the diagnostic imaging department (X-ray department) and is a separate facility from the children's ED. It has an allocated minor injuries unit facilitating one trolley and four couches, clinical examination cubicles, a four-bay emergency and resuscitation room, 10-bed Clinical Decision Unit and three single rooms. At the time of the investigation, there were no dedicated isolation facilities available within the ED. The ED had a patient information and tracking Information Technology (IT) system in place.

In 2010, the HSE in conjunction with the Hospital had identified a requirement to re-design the ED and create an initial assessment unit. It was reported at interview, and evidenced in the documentation received, that this development would enhance the patient journey by increasing the ED's capacity to clinically assess patients in a timely manner. Accordingly, it was reported by Hospital staff and the HSE that capital funding had been allocated in 2011 to complete this work. However, at the time of the investigation this work had not commenced.

As illustrated in Table 4, the total number of adult ED attendances at the Hospital in 2010 was 41,534, with 20,522 attendances recorded for the period from January to June 2011. For both periods, 31% of patients attending the ED were admitted.

Table 4: Adult Emergency Department activity by volume of attendances and admissions and by ratio of admission in 2010 and from January to June 2011

Adult Emergency Department activity	2010	(January to June) 2011
Adult Emergency Department (ED) attendances	41,534	20,522
Adult Emergency Department (ED) admissions	13,073	6382
ED admissions as a percentage of ED attendances	31%	31%

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

5.2.1 Referral Pathways

The data provided shows that the primary referral pathways to the ED were by self-referral (67%), referral by GP (21%) and other (3%).

During the on-site component of the investigation, which included an inspection of the Emergency Department, it was reported by ED staff that acutely ill emergency patients brought by ambulance to the Hospital were transferred directly to the main ED resuscitation room, where the ambulance services alerted the ED of their expected arrival time and the patient's clinical status. The timely and full handover of patients from an ambulance crew to ED staff is a crucial stage of an unscheduled patient journey, and should be monitored accordingly by all hospitals providing emergency services to identify any deficiencies or areas of potential improvement.

The majority of patients attending the ED at the Hospital were self-referrals. At the commencement of the investigation, there was no local out-of-hours GP or primary care service available in Tallaght. It is reasonable to suggest that in the absence of an out-of-hours GP service or primary care centre, patients may perceive to have no choice but to attend the ED at the Hospital.^(18,19) It was found that a local out-of-hours GP service was scheduled to commence in November 2011. This service was to be provided by 42 GPs. During the investigation, the Hospital confirmed that the GP out-of-hours service had opened on 1 November 2011.

5.3 Governance in the Emergency Department

Effective governance is a pre-requisite for the sustainable delivery of safe, effective, person-centred services.⁽⁵⁾

At the time of the investigation, the ED was part of the Medical Directorate in the Hospital, with the emergency medicine (EM) consultants reporting to the Clinical Director for Medicine. The role of the Lead Emergency Medicine Clinician was rotated between the three EM consultants with the Lead EM Clinician attending the directorate meetings and participating within the directorate structure.

Within a well-governed service there are clear lines of accountability at individual, team and service level.⁽⁵⁾ However, it was reported that the directorate structure was not supportive of the operational arrangements for all ED staff. For example, the Clinical Nurse Manager with operational responsibility for the ED was accountable to more than one individual for the operational functioning of the ED. This resulted in the absence of one clear line of accountability and reporting. Such deficiencies in governance structures could contribute to the non-alignment of the management of unscheduled care at a hospital. The clinical directorate structure at the Hospital will be further explored in Chapter 10.

Arrangements were in place for the twice daily clinical handover of patients within the ED and the Clinical Decision Unit by senior clinical decision makers working within both departments. The ED managed all clinical incidents, patient complaints and adverse events in line with the Hospital's policies and procedures. However, the Authority was not satisfied with the efficacy of these processes. It was reported at interview, and evidenced in the documentation received, that emergency medicine consultants had written and reported concerns to the Hospital's Executive Management Team, Medical Board and the Board, with specific reference to the use of the corridor adjacent to the ED for admitted patients and the boarding of admitted patients within the ED itself. In addition, it was reported at interview that other ED staff had formally reported concerns within their line management structure, for example, in relation to patient overcrowding and the potential risk to patient and staff safety. Variable levels of formal responses to these concerns were reported at interview, and evidenced in the documentation reviewed. This will be further explored in Chapter 10.

The review of documentation identified that in 2010, a total of 331 patient clinical incidents were reported in relation to the ED (n=304) and the corridor adjacent to the ED (n=27). The most frequent type of clinical incidents reported in the ED were related to treatment (48%, n=154), slips, trips and falls (16%, n=52), absconded patient (10%, n=32) and medication (7% n=23). In 2011, two unexpected patient deaths occurred within the ED, one in March and the second in July. As reported by the review commissioned by the Hospital's Forum for Adverse Incident Review (FAIR) of the incident in March, the contributing factors centred on the sub-optimal environment of the corridor adjacent to the ED for the accommodation of patients, a lack of an early warning system (EWS) to rapidly identify a patient whose clinical condition is deteriorating, lack of a structured communication process between hospital teams and limited nursing documentation and care plans for admitted patients while awaiting admission to an inpatient ward.

Operationally, there were weekly ED departmental meetings. These were chaired by the Lead EM clinician and included the senior nurse manager and EM consultants. In addition, there were six-weekly multidisciplinary meetings with both committees having terms of reference and recorded minutes. The primary purpose of these meetings was to share information. As it was not possible for all staff to attend, it was found that the ED management team disseminated a two-monthly publication to update staff. However, at the time of the investigation this publication had not been available for six months. In addition, it was unclear to the Authority how the actions or recommendations of these ED specific committees fed into the Hospital's directorate, bed management, operational or executive structures. This is further reflected in the findings outlined in Chapter 10.

To effectively manage unscheduled patient care, and to direct ED activity and drive improvement, it is imperative that the Hospital's operational and executive management structures, with the assistance of the NEMP, have the necessary arrangements in place to implement the NEMP and to provide assurances of the quality and safety of unscheduled patient care to the Board of the Hospital.

5.3.1 Accountability for the Patient

The patient should know who is in charge of their care at all times. To ensure a safe quality service it is imperative that patients, at all times, have a designated consultant who is clinically responsible and accountable for their care. Where a patient moves between clinical services there must be a timely, formal, handover of information and accountability between consultants and their respective clinical teams. This should be communicated to the patient or their family member/carer.

(18)

Patients who attended the ED were under the care of the EM consultant, until a decision to admit or discharge was made. During the course of the investigation, a new operating policy had been introduced to ensure a seamless transfer of clinical responsibility for a patient from the stage of clinical assessment in the ED, to the stage of clinical assessment by the relevant specialty hospital team and to the stage of admission to a hospital ward. It was found during the observation and inspection carried out by the Investigation Team, and confirmed at interview, that engagement was ongoing between the ED consultants, the Clinical Directorates and the Medical Board in relation to its implementation. However, an agreement had not been formalised and not all clinicians fully agreed with the policy.

The absence of such an agreement posed a serious potential risk to patients. Consequently, the Authority wrote to the Chief Executive of the Hospital seeking assurances that a patient has a designated consultant responsible for their care at all times. (See Appendix 5.) The Chief Executive responded with assurances that the policy had been fully implemented and that monitoring mechanisms had been put in place.

5.4 Workforce

To ensure a safe quality service to patients attending the Emergency Department (ED), a senior clinical decision maker at registrar or consultant level should be on site in the ED at all times. (18,20)

At the time of the investigation, there were two full-time consultants in emergency medicine (EM) with a third providing 33.5 hours to the Hospital (and 3.5 hours to Naas General Hospital) and a fourth providing three hours in total to the Hospital and the remainder to Naas General Hospital.

The position of Lead EM consultant was rotated between all EM consultant post-holders with a majority of working hours committed at the Hospital (that is, those full-time at the Hospital, and those who had sessional commitments at more than

one hospital, but with the majority of their sessions at the Hospital). A review of the EM consultants' work plan submitted by the Hospital indicated that the consultant staff provide clinical cover mid-week from 08.00 – 18.00 hours with an off-site on-call cover arrangement to include on-site clinical support for up to five hours in total at the weekend. At the time of the investigation, there were no locum arrangements in place for consultant leave.

It was reported at interviews that the roster arrangements, and the number of EM consultants available at the Hospital, meant that at times patients had to wait for prolonged periods to be seen by a senior clinical decision maker at consultant level. It was reported to the Investigation Team that the Hospital had made efforts to change the working arrangements within the ED. These efforts were consistent with the draft report of the NEMP which supports that an increase in the on-site availability of emergency medicine consultants working in the ED would improve the quality, access and cost effectiveness of care. At the conclusion of the investigation, the Authority was informed that a fourth EM consultant was due to commence at the Hospital in June 2012.

At the time of the investigation, non-consultant hospital doctors (NCHDs) provided 24-hour seven-day on-site cover in the ED with a senior clinical decision maker at registrar or specialist registrar (SpR) level on each shift. A full-time Medical Officer (registrar grade) and one Advanced Nurse Practitioner (ANP) provided a minor injury service during core working hours.

A Clinical Nurse Manager 3 had overall ED nursing responsibility with a Clinical Nurse Manager 2 in charge of each shift. The core complement of ED staff included a GP liaison nurse, clinical nurse facilitators, staff nurses, post graduate nursing staff, care assistants and administrative staff. Allied health professional support was provided by diagnostic imaging, occupational therapy, physiotherapy and social work.

From a GP service perspective, the Draft National Emergency Medicine Programme, in tandem with international evidence, supports the enhanced involvement of GPs in emergency care.⁽¹⁸⁾ It was reported at the time of the investigation that there were no GPs working within the ED at the Hospital, which would not be considered unusual in the context of the Irish emergency medicine service.

5.5 Re-attendance to the ED

Re-attendance to an ED may occur for a variety of reasons including the nature of the patient's condition, the appropriateness of the care provided at initial attendance or access to community services post initial discharge from ED. International evidence suggests that patient re-attendance rates to the ED with the same clinical condition within seven days should be in the range of 1-5%.

^(18,19) Recording of re-attendance rates of patients attending the ED with the same clinical condition is a recognised international quality indicator.

Re-attendance to the ED at the Hospital was recorded within 21 days, as opposed to seven days, and did not differentiate between planned and unplanned re-attendances. The percentage of patients who re-attended within 21 days is illustrated in Table 5. The Authority was not provided with any information that indicated that the Hospital had a structured system in place to review re-attendance rates of patients who make an unplanned re-attendance with the same clinical condition within seven days to the ED.

Table 5: Percentage of patients who re-attended within 21 days of being discharged from the ED in 2010 and from January to June 2011

ED re-attendances within 21 days of discharge from ED as a % of total discharge from ED	2010 (Average)	Jan 2011	Feb 2011	March 2011	April 2011	May 2011	June 2011
Percentage	14%	15%	13%	14%	15%	15%	13%

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

Whilst acknowledging that re-attendance rates may vary, for example, in accordance with casemix, it would be expected of a hospital to periodically review the types of patients who are re-attending the ED and ascertain any underpinning causes for this in order to identify where there are improvements in the assessment and quality and safety of care provided and any actions that may need to be taken. From a national perspective, re-attendance rates to the ED should be adopted as a quality indicator of the patient journey, with the caveat of, and appropriate controls for, the varying demographics and clinical profiles of national EDs.

5.6 Patients who leave without being seen

Of the number of patients who will attend the ED of a hospital, a number of patients may leave the ED after they've been registered and/or triaged and prior to being seen by the clinical staff. Whilst there may be a range of reasons why a patient may leave the ED, for example, waiting long periods, the decision to leave may not always be fully informed and may have implications from the point of view of a patient's health or welfare.⁽²¹⁾ In particular, there is a risk that certain patients who leave the ED may have underlying health conditions which may deteriorate without treatment. International best practice indicates that the number of patients who leave the ED before being seen by a doctor should be kept to a minimum and on average, below 5% of the total patient attendances.⁽¹⁹⁾

The Investigation Team requested data from the Hospital pertaining to the numbers of patients who did not wait in the ED and left without being seen in 2010 and from January to June 2011. The average number of patients who did not wait in the ED of the Hospital and left without completing their care in the period from January to June 2011 was approximately 14%. The data provided included patients who had been:

- registered and left before triage
- registered and triaged, but left before being seen by a doctor
- registered, triaged and seen by a doctor but left the department without receiving clinical results.

Going forward, the National Emergency Medicine Programme identifies, as an indicator, the number of patients who leave before completion of treatment being below 5% of new attendances.⁽¹⁸⁾

In consideration of this, it would be expected of a hospital to periodically review the types of patients who are leaving without being seen and ascertain any underpinning causes for this in order to identify where there are improvements in the assessment, timeliness and quality and safety of care provided and any actions that may need to be taken. The Authority was not provided with information that the Hospital had a system in place to review the reasons patients leave the ED without being seen.

5.7 Patient journey for unscheduled care

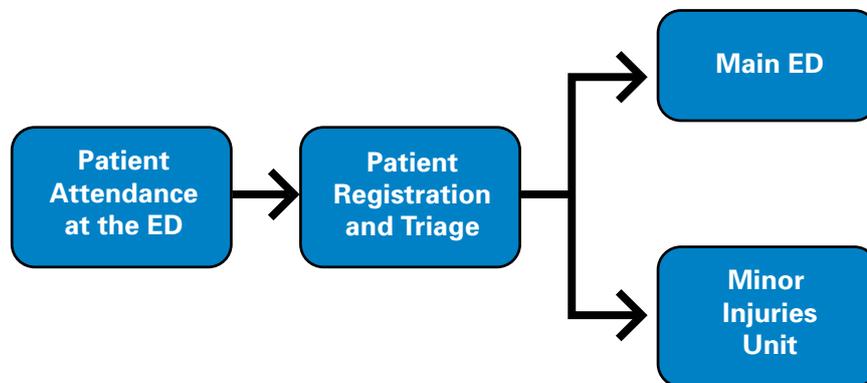
This section of the Report will discuss the main pathways found by the Authority in the ED of the Hospital, with Figure 1 illustrating the first phase of the patient journey (excluding that of Triage Category 1 patients as this category of patients should be brought directly to the resuscitation room of the ED).

To reduce the number of patients having to access a hospital through the emergency department it is necessary to have additional and alternative routes for urgent care and to have formal arrangements in place to ensure rapid access to a consultant opinion, supported by adequate diagnostic capacity and robust clinical protocols.⁽¹⁸⁾

At the time the investigation, the Hospital had a number of patient-admission-avoidance initiatives and clinical pathways in place. These included a Rapid Access Stroke Prevention Service, a Nurse Led Community Intervention Scheme, Chronic Obstructive Pulmonary Disease clinical pathway and a Chest Pain service. However, staff considered that the implementation of the National Acute Medicine Programme at the Hospital would have potentially the most significant impact for patients, this will be further discussed in Subsection 5.12.

5.7.1 Patient Registration and Triage

Figure 1: Emergency Department patient journey/pathway



To ensure that a patient attending an ED is seen in order of their clinical need rather than in order of their time of attendance, the hospital should have a patient triage system in place. The National Emergency Medicine Programme recommends that the Manchester Triage System (MTS)⁽²²⁾ is used in all Irish EDs. The MTS is an internationally recognised method of clinically prioritising each patient seen (category range from 1 to 5) thereby ensuring that the patient is seen in order of clinical need.⁽²²⁾ The MTS uses a series of algorithmic aids to assign the most appropriate category of urgency which defines the target time of first contact with the treating clinician based on clinical priority.

The MTS includes 5 categories of urgency, these are:

category 1	Immediate
category 2	Very Urgent
category 3	Urgent
category 4	Standard
category 5	Non-Urgent

The MTS, which included pain assessment, was the system used at the Hospital with some nursing staff qualified to prescribe pain relief.

At the time of the investigation, acutely ill and major trauma patients were immediately transferred to the 'major treatment room' while all other patients were registered at the reception desk by administration staff. After the patient registered they were then triaged by a registered nurse.

International and national best practice suggests that patient registration and triage should occur at the same time thereby reducing patient waiting times and providing timely patient assessment and treatment. In order for any system to be

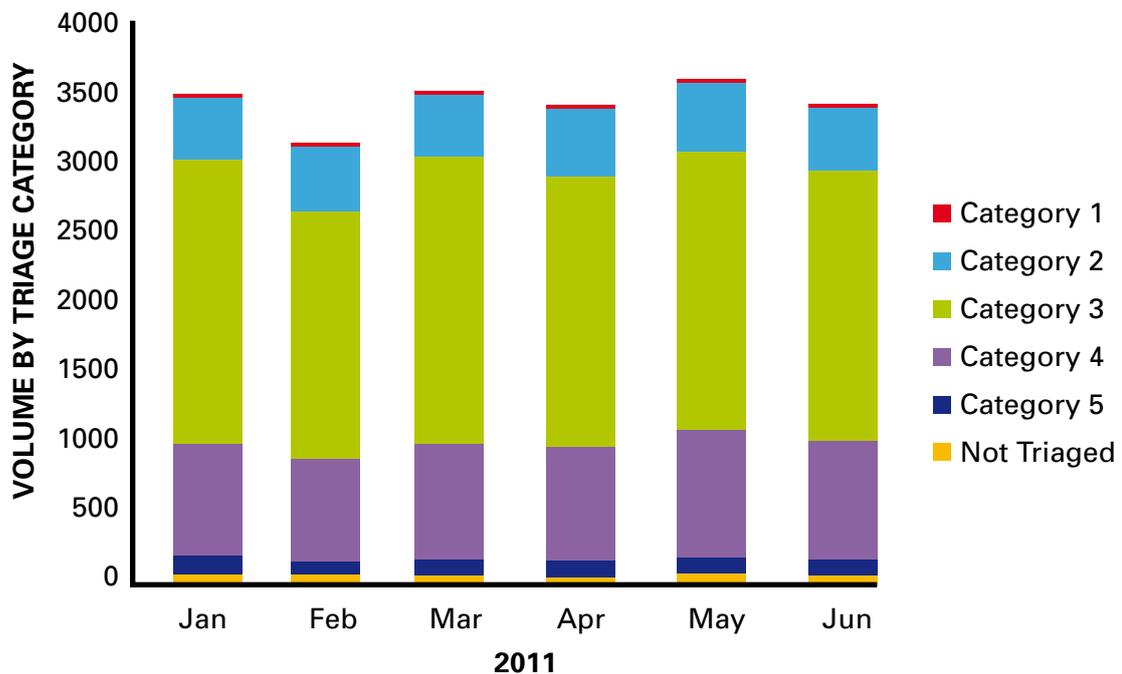
effective, staff must be proficient in the use of the triage system which should be monitored on an ongoing basis to identify and address any deficiencies. An audit of the accuracy in the use of the Manchester Triage System was conducted at the Hospital in 2010. The findings concluded that of the 79 cases reviewed, 86% of the 79 patients were accurately triaged. However, the audit did identify that 27% of the 79 cases reviewed did not have the entire data field completed and some of these were incorrectly triaged. Whilst it was reported at interview that all senior staff were proficient in the use of the system, some junior staff nurses had not attended any formal triage training and/or had not had supervised practice in patient triage. At the time of the investigation a refresher course had not been conducted in the last six months to address the findings of the above audit.

A three-month analysis of triage data across the Dublin Academic Teaching Hospitals EDs in 2008 showed the pattern of triage distribution in the Hospital was similar to the other hospitals. The Authority analysed the data submitted by the Hospital which indicated that from January to June 2011:

- 1% of patients were triaged as category 1
- 14% as category 2
- 56% as category 3
- 24% as category 4
- 3% as category 5
- 2% were reported as not triaged.

Figure 2 illustrates the volume of Emergency Department adult attendances by assigned triage category from January to June 2011.

Figure 2: Volume of Emergency Department adult attendances by triage category from January to June 2011



Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

Considering that 67% of all attendances at the adult ED in the Hospital were self-referred, the data provided could potentially suggest that the number of patients assigned a triage category 2, 3 and 4 was not accurate or that the acuity of patients attending the Hospital is exceptionally high. This was explored at interview where it was found that a higher prioritisation triage category may have been applied by staff in an effort to expedite the patient journey. The Authority was advised that this phenomenon was not exclusive to the Hospital, with similar practices being reported both nationally and internationally. This practice, if not recognised, could potentially distort the clinical profile of attendances at the ED, which may adversely impact on forward planning of the ED and the prioritisation of need of all the patients attending an ED at any given time. As the MTS is the identified national triage system going into the future, it is essential that appropriate ongoing staff training and education is put in place. The application of the system should be monitored and any required actions implemented as a result in order to ensure a consistent application of the system nationally.

At the Hospital, a secondary triage service was provided by the occupational therapy and social work departments for patients over 65 years of age and patients with complex social/care needs. At the time of the investigation this service, when available, was found to be beneficial in the management of this vulnerable patient group and in effectively contributing to the timely discharge of patients. However, the service did not have funded input from physiotherapy and was only available during core working hours, with arrangements in place to identify out of hours patients who would potentially benefit from this service. In recognition of the reported benefits of this service, the Hospital should give consideration to the expansion of this service beyond core hours.

Following triage, and depending on the patient's clinical condition, a patient may be seen in either the Minor Injuries Unit or within the main ED.

5.7.2 Minor Injuries Unit

Internationally, it is reported that minor injuries/illnesses account for between 30% to 60% of all attendances to the ED.⁽²³⁾ At the time of the investigation, there were guidelines in place for the appropriate referral and management of patients to the Minor Injuries Unit.

The ED minor injury facility at the Hospital was located adjacent to the patient waiting and triage area. At the time of the investigation, this service was permanently staffed during core working hours by a Medical Officer (registrar grade) and one Advanced Nurse Practitioner (ANP), with additional support provided by the ED staff.

Figure 3 outlines the pathway for patients with minor injuries through the Hospital's Emergency Department.

Figure 3: Emergency Department Minor Injuries Patient Journey/Pathway



International evidence and systematic reviews indicate that suitably qualified and experienced nurse practitioners when working with clear clinical guidelines reduce waiting times in the ED, improve continuity of patient care and are cost effective and safe.^(24,25) Although it was reported that funding was in place for a second ANP post, the Hospital had, over the last three years, been unsuccessful in filling this post. However, it should be noted that hospitals of a similar size in Dublin have, over the last number of years, enhanced their ED services by increasing their number of ANPs.

At the time of the investigation, this service was working well during core hours. However, the role of the ANP, due to internal constraints, had not extended to include the requesting of X-rays. In practice, this meant that patients who had been clinically assessed by the ANP and required an X-ray had to wait until a non-consultant hospital doctor signed the request form. The Authority recognises that this challenge is not specific to the Hospital and recommends that nationally, nurse prescribing of imaging diagnostics be supported and expanded.

Outside of core hours, the minor injury service was provided by the ED clinical staff, rather than advanced nurse practitioners. As a result, it was reported at interview that when the ED was busy, patients with minor injuries sometimes had to wait for extended periods to be seen and treated.

The provision of nurse-led minor injuries services at the Hospital, if adequately resourced and structured, would effectively reduce the waiting times for patients with minor injuries, improve patient flow and could lead to a more effective utilisation of clinical staff.

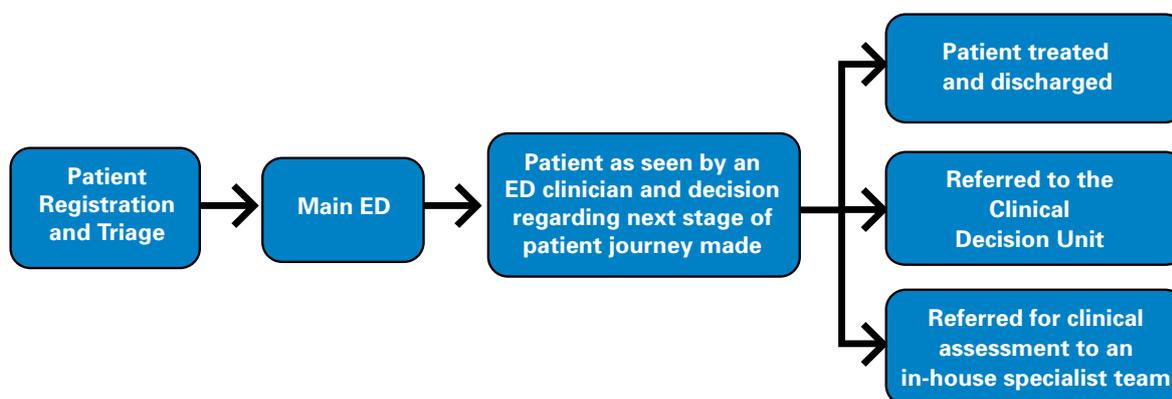
5.7.3 Main Emergency Department

As referenced at the outset of this section, there was direct access to the resuscitation room of the Emergency Department for emergency admissions (Triage category 1). Patients outside of this patient group, and those patients with minor injuries after they had been registered and triaged, were seen within the ED.

As illustrated in Figure 4, at this stage in the patient journey, a patient may be:

- treated and discharged (see Subsection 5.8.4)
- admitted to the Clinical Decision Unit (see Subsection 5.8.5)
- referred for clinical assessment by an in-house specialist team (see Subsection 5.8.6).

Figure 4: Main Emergency Department Patient Journey/Pathway



This investigation focused primarily on patients who required admission.

5.7.4 Patients Discharged (non-admitted patients)

International literature suggests that there is an increase in adverse outcomes for patients who have been in the ED for more than four to six hours.^(18,26) Therefore, long waiting times (that is, greater than six hours) should be an exception and arrangements should be in place to formally monitor and review patient waiting times and any associated actions and improvements required in the model of care should be implemented.⁽²⁷⁾

Table 6 illustrates the length of time spent in the ED in the Hospital for non-admitted patients. This includes patients discharged by the ED team or in-house team. It was reported that some of the shorter waiting times could, for example, relate to patients from other hospitals that pass through the ED to an inpatient bed or patients returning to receive a sick certificate.

Table 6: Length of time in the Emergency Department at the Hospital for non-admitted patients (hours:minutes)

Non-Admitted Patients	Jan 2011	Feb 2011	Mar 2011	April 2011	May 2011	June 2011
Shortest waiting time	00:08	00:12	00:11	00:16	00:09	00:07
Longest waiting time	61:09	31:48	49:08	28:22	29:18	28:33
Mean waiting time	06:40	06:19	07:07	06:49	06:38	06:12

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

Whilst the Authority recognises that the mean waiting time for a non-admitted patient was within six to seven hours, it is wholly unacceptable that patients were waiting within the ED for up to 61 hours before being discharged.

5.7.5 Admission to the Clinical Decision Unit (CDU)

At the time of the investigation, the Hospital was one of seven Irish hospitals with a Clinical Decision Unit (CDU). This 10-bed facility was located within the ED and was managed by the EM consultants. The main purpose of a CDU is to enable safe, effective and timely decision making for patients who present to the ED with specific emergency conditions whose length of stay is likely to be no longer than 6-24 hours duration.^(28,29) The CDU at the Hospital was fully open with strict admission criteria and supporting standard operating procedures for a range of patient conditions which included deep venous thrombosis, pulmonary embolus, head injury, ureteric colic and cellulitis. The emergency medicine consultant assigned to the CDU at the Hospital conducted ward rounds in the CDU where all the patients were formally clinically reviewed twice daily.

A CDU should be supported by timely access to, and reporting of, diagnostic tests (for example, blood tests, plain film X-rays and computerised tomography scans (CT)). Whilst access to laboratory diagnostics was reported as satisfactory by the clinical staff interviewed, patients could be waiting extended periods of time for access to diagnostic imaging, which resulted in patients remaining within the CDU outside of the ideal timeframe for patients in the unit. The length of stay timeline of 6 to 24 hours is key to the efficient operation of a CDU.

5.7.6 Referral to a Specialist In-house Team for a Decision to Admit or Discharge

Following clinical assessment by an ED clinician, a patient may be referred to an in-house (within the Hospital) specialist team for further assessment. An in-house specialist team could be for example, general medical, surgical, orthopaedic, cardiology or neurology.

At the time of the investigation, from a general medical in-house team perspective, there was one registrar and two senior house officers (SHOs) allocated to the ED during core hours, with surgical cover provided by the on-call team. Outside of core hours, the on-call medical and surgical teams provided cover to the ED with specialist teams, for example, vascular and orthopaedics providing off-site on-call cover. Cardiology was available in-house up until midnight.

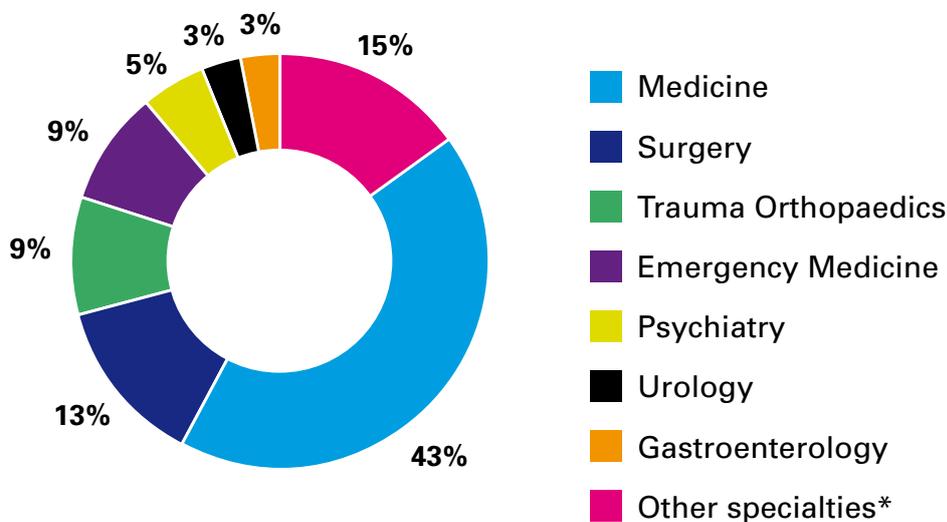
It is essential that on-call teams are always available to the ED to provide timely assessment and reduce patient waiting times in the ED. During core hours, the availability of in-house teams was generally satisfactory with a response time being reported at interview and in the data reviewed as, on average, under two hours. However, delays could occur if, for example, on-call teams were providing outpatient services or in theatre, with delays reported in the data submitted by the Hospital of up to seven hours.

In recognition of the potential significance of this risk to the quality and safety of a patient's care, during the investigation the Authority raised its concerns in writing with the Chief Executive of the Hospital (see Appendix 5). The Chief Executive responded with assurances that staff roster arrangements were in place to ensure the availability of on-call teams to the ED. The Authority recognises that the significance of this risk pertains to all hospitals providing ED services in Ireland.

5.8 Patients requiring admission after having been clinically assessed by the specialist in-house team

In the first six months of 2011, the majority of ED patient attendances requiring admission were admitted under the care of a medical specialty (43%), surgical specialty (13%), emergency medicine (9%) and trauma and orthopaedics (9%). This is reflective of the trend for 2010. Figure 5 below illustrates the percentage of patient admitted from the ED by specialty.

Figure 5: Percentage of Patients by Specialty Requiring Admission from January to June 2011



Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

Once a decision to admit a patient was made, the ED nursing staff notified the Bed Management Office during core hours and the out-of-hours Nurse Manager with responsibility for bed allocation outside of core hours. Whilst awaiting the allocation of an inpatient bed, it was found that waiting patients could be accommodated either within a designated area within the ED or on the

* Other specialties includes a range of specialties such as cardiology, gynaecology, respiratory medicine, secondary trauma orthopaedics and ear, nose and throat with an admission rate of less than 2%.

corridor adjacent to the ED. In addition, since 2010, the Hospital had developed and implemented an ED escalation policy. This policy identified the operational arrangements in place at the Hospital when the ED was at full capacity and with over 10 patients awaiting admission

At the time of the investigation, formal nursing criteria were in place to identify the location of where an admitted patient would wait pending transfer to an inpatient bed. The following are areas where patients awaiting an inpatient bed were accommodated in the Hospital and the types of patients who were placed in these areas:

- ED major treatment rooms 1 and 2: very ill patients requiring full nursing care were to be accommodated
- corridor adjacent to the ED: where possible, ambulatory patients were to be accommodated
- minor treatment room 1-3 (single rooms): patients requiring isolation, or full nursing care, were to be accommodated.

At the time of the investigation, patients awaiting admission in any of these areas were under the care of the in-house specialty team, with an emergency response being provided by the ED staff should a patient's condition deteriorate. It was reported at interview by clinical staff that the Early Warning Score (EWS) was being piloted on two wards in the Hospital with a further plan to roll it out to all departments. However, at the time of the investigation the Hospital did not have an Early Warning Score in place to rapidly detect and respond to a patient whose condition was deteriorating within the ED or on the corridor adjacent to the ED. It is not acceptable that an EWS was not in place given that the Authority had previously recommended in the *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Services Executive at Mallow General Hospital (2010)*⁽⁶⁾ that an EWS be implemented in all hospitals in Ireland and that the HSE should ensure a system-wide application and dissemination of this.

Subsequently, in March 2012, it was confirmed that the HSE's national clinical care programmes formally launched a National Early Warning Score (NEWS) to be implemented in all hospitals.⁽³⁰⁾

5.9 Patients awaiting admission within the main ED

International evidence and best practice indicates that patients should be seen and admitted (if appropriate) within six hours.⁽¹⁸⁾ Table 7 illustrates the waiting time for admitted patients (that is those patients where a decision to admit has been made) in the ED at the Hospital before being transferred to an inpatient bed or to the corridor adjacent to the ED.

Table 7: Waiting time for patients in the main ED before admission to an actual inpatient bed from January to August 2011 (hours: minutes)

	Jan 2011	Feb 2011	Mar 2011	April 2011	May 2011	June 2011	July 2011	Aug 2011
Shortest waiting time	00:03	00:01	00:08	00:02	00:01	00:06	00:04	00:05
Longest waiting time	28:28	32:41	31:18	31:41	29:58	34:44	33:16	32:43
Mean waiting time	08:00	07:21	07:58	07:51	07:17	07:08	06:58	07:28

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

In the context of the data provided by the Hospital, whilst the mean waiting time was in the range of seven to eight hours, it is unacceptable that patients could experience waiting times of up to 34 hours from decision to admit to transfer to an inpatient bed. This data contributed to the decision by the Authority to undertake an unscheduled inspection of the ED in the Hospital on 24 August 2011. This will be discussed in detail in Chapter 6.

It was reported at interview that arrangements were in place for admitted patients in the ED who were awaiting transfer to an inpatient facility to be reviewed by their clinical teams early each morning. This will be further discussed in Chapter 6.

5.10 Patients awaiting admission on the corridor adjacent to the ED

At the commencement of the investigation, some patients who were admitted and awaiting an inpatient bed were accommodated on the corridor adjacent to the ED in addition to admitted patients boarded within the main ED. It was said by clinical staff interviewed that the corridor adjacent to the ED was considered as a short-stay area for admitted patients to wait until an inpatient bed became available and that the numbers of patients allocated to the corridor had been incrementally reduced as a result of hospital efficiencies over the previous number of months.

Table 8 illustrates for the total number of admitted patients through the ED for the three-month period between April and June 2011. Of that number, a mean of 86% of the total number of admitted patients were allocated to wait on the corridor adjacent to the ED. This meant that for example, during May 2011, 971 of the 1068 patients requiring admission to the hospital were accommodated on the corridor adjacent to the ED.

Table 8: Total Number of ED admissions and associated percentage allocated to corridor adjacent to the ED from April to June 2011

Emergency Department Admissions	April 2011	May 2011	June 2011
Total number of Emergency Department adult attendances requiring inpatient admission	1076	1068	973
Percentage of total number of Emergency Department adult attendances requiring inpatient admission allocated to the corridor adjacent to the ED	82%	91%	84%

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

It was reported by some of the in-house clinical staff that they found the use of the corridor to accommodate admitted patients as upsetting and that they were professionally embarrassed in having to review their patients on the corridor. However, in general, those in-house clinical and non-clinical staff interviewed did not perceive the use of the corridor for admitted patients to be clinically unsafe. Although recognising the undesirability of the use of the corridor for admitted patients, this practice had become an accepted norm within the Hospital. Having regard to the risks posed to the health and/or welfare of patients, the acceptance and tolerance of such practice is not acceptable in any ED in Ireland and should cease.

Table 9 shows that patients could be waiting on average 13 hours, with the longest reported time being reported as 140 hours before being transferred to an inpatient ward. In practice, this meant that ill patients waited on a corridor. This is unacceptable.

During the observation component of the investigation, the Authority viewed the corridor adjacent to the ED. This corridor was a main thoroughfare for people and patients attending the X-ray department. Ill patients lay waiting on patient trolleys or sat on armchairs, with an unacceptably low level of privacy or dignity. The physical congestion and absence of basic facilities associated with the use of the corridor as a waiting area for ill patients, compromised the quality and safety of care for these people and also compromised the assessment of newly arriving patients in the ED.

Table 9: Total waiting time (hours:minutes) for patients in the corridor adjacent to the ED before admission to an inpatient bed

Length of time on corridor adjacent to ED	Jan 2011	Feb 2011	Mar 2011	April 2011	May 2011	June 2011	July 2011	Aug 2011
Shortest waiting time	00:01	00:04	00:05	00:06	00:03	00:02	00:06	00:03
Longest waiting time	116:38	95:43	138:20	90:36	140:57	95:13	93:08	72:32
Mean waiting time	18:19	17:30	17:05	11:25	16:45	12:09	13:06	09:09

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

The Authority was concerned by the Hospital's persistent and generally accepted use of a corridor to accommodate ill patients as this posed a potential risk for patient safety and/or welfare. This finding, in addition to the data submitted that indicated the excessive waiting times for ill patients waiting on the corridor, prompted an unannounced inspection by members of the Investigation Team to the ED at 9.15am on the 24 August 2011. This is further discussed in Chapter 6.

5.11 National Clinical Care Programmes

Notwithstanding the local elements that contribute to a hospital effectively managing patient admission and discharge processes for unscheduled and scheduled care, there are wider national clinical initiatives which the HSE suggests will contribute to solutions to the key points of the patient journey.

The first National Clinical Care Programme published by the HSE is the Acute Medicine Programme.⁽¹⁷⁾ This programme is a clinician-led initiative between the Royal College of Physicians of Ireland (RCPI), the Irish Association of Directors of Nursing and Midwifery (IADNAM) and the Therapy Professional Committee (TPC).

The HSE report that the benefits of fully implementing the National Acute Medicine Programme (NAMP)⁽¹⁷⁾ in a hospital include:

- a reduction in the admission rate of medical patients by 10% per year for three years
- every patient presenting to the Acute Medicine Unit or equivalent being seen by a senior doctor with one hour
- generating medical bed day savings of 10% per year for three years
- preventing unnecessary duplication and delays in clinical assessment, diagnosis and treatment of medical patients.

In the context of the Hospital, it was reported that 44% of emergency department patients requiring inpatient admission were medical patients. Accordingly, the National Clinical Care Programme, with an initial focus on acute medicine, offers the Hospital an opportunity to streamline the patient journey for the acute medical patient.

As part of the NAMP implementation, a pre-implementation diagnostic was conducted at the Hospital in February 2011 by consultancy staff contracted by the HSE Clinical Care Programme to assess the readiness of the Hospital for implementation of the Programme. Whilst the report was complimentary in relation to the staff and their commitment to patient care, in line with the Authority's findings for unscheduled care, a number of key areas were identified as requiring attention. These included:

- introducing an early warning score
- developing an implementation plan for the NAMP
- identifying a multidisciplinary team to manage the change
- ensuring full clinician support
- improving diagnostic access times
- enhancing and corporately supporting the bed management department and patient discharge planning processes.

The HSE National Directorate of Clinical Strategy and Programmes reported in January 2012 that the Hospital had made major progress in the implementation of the National Clinical Care Programmes, which was supported by documentation provided by the HSE to the Authority.

5.12 Conclusions

The patient referral pathways to the Emergency Department of the Hospital were found to be similar to those of other hospitals in Ireland with a similar profile, and with the majority of patients being self-referred. The lack of an out-of-hours general practice or primary care service in the area meant that patients and/or their GPs may have felt that they had no other option but to attend or refer the patient to the Hospital's Emergency Department to expedite their treatment.

Of the total number of patients who attended the ED of the Hospital for the first six months of 2011, 14% left without completing their care. Whilst there may be a range of reasons why these patients left, including for example, waiting long periods, there is a risk that patients who leave may have underlying health conditions which could deteriorate without treatment. The Hospital should ascertain any underpinning causes for this in order to identify where there are improvements that might be made in the assessment, timeliness and quality and safety of care provided, and any resultant actions that may need to be taken.

Patient re-attendance to the ED was recorded within 21 days of first attendance, and did not differentiate between planned and un-planned re-attendances. The Authority was not provided with any information that indicated that the Hospital had a structured system in place to review re-attendance rates of patients who make an unplanned re-attendance with the same clinical condition within seven days to the ED.

The patient and the hospital must know who is in charge of the patient's care at all times. While the patient was in the ED and Clinical Decision Unit they were reported as being under the care of the emergency medicine consultant. However, when the patient was referred by the emergency medicine team to be assessed by an in-house specialty team elsewhere in the hospital, the Authority found that it was unclear who the designated consultant with responsibility for the patient's care was following this referral and prior to the patient's acceptance by the in-house specialty team.

This ambiguity posed a potentially serious risk to patient's health and welfare. Consequently, the Authority raised this with the Chief Executive of the Hospital who responded with assurances that an operational policy had been fully implemented to ensure that the patient was under the care of a consultant at all times, and that monitoring mechanisms around this had been put in place.

The mean waiting time for a non-admitted patient in the ED was in the spectrum of six to seven hours. However, the Hospital also reported patients waiting within the ED for up to 61 hours before being discharged. The mean waiting time for admitted patients waiting for transfer from the ED to an inpatient ward was an average of seven hours with some patients experiencing wait times of up to 34 hours. In the Hospital, 86% of all admitted patients were allocated to a corridor adjacent to the ED to await transfer to an inpatient facility. Patients could be waiting on average 13 hours, with the longest reported time being reported as 140 hours, before being transferred to an inpatient ward. This was an unacceptable situation for patients.

This corridor was a main thoroughfare for people and patients attending the X-ray department. Ill patients lay waiting on patient trolleys or sat on armchairs, with an insufficient level of privacy or dignity. The physical congestion and absence of basic facilities associated with the use of the corridor as a waiting area for ill patients compromised the quality and safety of care for these people and also compromised the assessment of newly arriving patients in the ED. These findings were in line with the experiences of a number of patients who had contacted the Authority in relation to their episode of unscheduled care at the Hospital.

The use of the corridor at the Hospital was wholly unacceptable to the Authority and it prompted an unannounced inspection by members of the Investigation Team to the ED on 24 August 2011.

At the time of the investigation, work was ongoing at the Hospital to reduce the waiting times for admitted patients to be transferred from the Emergency

Department (ED) to an inpatient facility. This was in tandem with a number of national initiatives that were in various stages of development, including the National Acute Medicine Programme which was at the early stages of implementation, and the National Emergency Medicine Programme, which, at the time of the investigation, was being finalised for publication in 2012, and a range of initiatives of the Special Delivery Unit of the Department of Health.

In addition to the national initiatives outlined above, any acceptance or normalising of the use of inappropriate unfit-for-purpose arrangements (for example, a hospital corridor or a parking area for trolleys) to accommodate any patient receiving clinical care must be addressed and ceased by each hospital at a local level. Unacceptable practices of this type must not continue to be accepted as the norm in the Irish health service.

6 Unannounced Inspection of the ED at the Hospital from 09:00 hours to 11:30 hours on 24 August 2011

Due to the concerns of the Authority on receipt of information pertaining to the care of patients on the corridor adjacent to the Emergency Department (ED), it was decided that an unannounced inspection of the ED of the Hospital would be undertaken by members of the Investigation Team on 24 August 2011 from 09:00 hours to 11:30 hours in accordance with Section 73 (1)(b) of the Health Act 2007.⁽¹⁾

The rationale behind the unannounced inspection was to assist in ensuring, as far as was reasonably practicable, that what was observed by the Authority was reflective of a sample 'typical' day in the ED at the Hospital. It also provided the Authority with an opportunity to meet with staff working within the ED. The Authority observed both the corridor adjacent to the ED and the ED itself. In tandem, the Hospital was asked to provide detailed data pertaining to the patients within the ED on this date (see Appendix 6).

Due to the transient nature of an ED and given the context that patients are constantly being transferred, admitted or discharged, the figures pertain to a moment in time as opposed to a constant daily picture.

6.1 Findings

On arrival at the ED, the Authority found the waiting area vacant, with no patients waiting to be registered, triaged or seen. Within the ED, at approximately 9am, the Authority was advised that there were 51 patients in the ED, 22 of the 51 being admitted patients awaiting admission to an inpatient ward. Of the 22 admitted patients, six of these patients had been in the ED for more than 24 hours. Ten admitted patients were boarded within the main ED, and the remaining 12 on the corridor adjacent to the ED.

Three of the 22 admitted patients who required isolation were placed in clinical rooms in the ED. One of whom, with a provisional diagnosis of tuberculosis, had been accommodated for more than 72 hours in a clinical room. These clinical

rooms being used as isolation rooms were observed not to have appropriate isolation facilities and opened directly onto a corridor where other patients were being cared for. This was of serious concern to the Authority, and was raised with the Chief Executive of the Hospital in correspondence which was issued by the Authority pursuant to the unannounced inspection (see Appendix 7). Correspondence issued to the Authority by the Hospital's Chief Executive in response outlined the challenges of providing isolation facilities in the acute hospital setting.

Subsequently, it was reported at interview, and evidenced in documentation, that revised infection prevention and control guidelines were implemented in October 2011 which addressed senior decision making in relation to the isolation of patients within the Hospital, including the ED. At the time of the investigation, these revised guidelines had not been in place long enough for the Authority to assess their efficacy.

6.1.1 Workforce

On the morning of the unannounced inspection, the ED had its full complement of NCHDs, nursing staff, administration and auxiliary staff, with two emergency medicine consultants on duty, one of whom was in charge of the Clinical Decision Unit and the second consultant conducting structured board (clinical update) rounds within the ED and providing on-site senior clinical decision making.

6.1.2 Clinical Decision Unit

The Clinical Decision Unit was full on the morning of the unannounced inspection with the responsible consultant undertaking patient rounds which were reported to have commenced at 8.30am. There were two additional patients who should have been admitted to the CDU. However, at the time of the unannounced inspection, these patients were being accommodated on the corridor adjacent to the ED, pending the availability of beds within the CDU.

6.1.3 Corridor Adjacent to the ED

The Hospital considered the use of the corridor adjacent to the ED as a common practice and it was used as a short-stay arrangement until an inpatient bed became available. The Authority would acknowledge that whilst the infrastructure of short-stay areas will vary from hospital to hospital, it is reasonable to expect the following as the minimum criteria that a patient should expect in a short-stay area whilst awaiting transfer:

- the privacy and dignity of patients is preserved
- patients have access to toilet and washing facilities
- the short-stay area is not a public or staff thoroughfare

- there is sufficient space between the beds to allow visitors to be seated in comfort
- there is a facility for patients to securely store their belongings
- there are appropriate levels of nursing and clinical cover
- there is the appropriate level of, and access to, clinical monitoring equipment.^(18,31)

At the time of the inspection, there were 12 patients on trolleys in the corridor adjacent to the ED, nine of whom were within the clinical admission criteria for the corridor. Two of the remaining three patients were awaiting admission to the CDU, and a third patient had been referred by the ED for review by an in-house team. However, at the time of the inspection, this patient had not been seen by the in-house team. Therefore, three of the patients on the corridor were outside of the Hospital's admission criteria for the use of the corridor.

The corridor was the main thoroughfare to the imaging department for both the adult and children's Emergency Department. At the time of the inspection, admitted patients were lying on trolleys or sitting on armchairs in line with the corridor wall. Nursing care was provided by hospital nurses working agreed additional hours (bank nursing staff) with a lead nurse coordinating the service. Patients were being examined by clinical staff or receiving care from the nursing staff, at the same time as people were walking by them going to and from X-ray. There was no privacy or space for patients to be clinically examined or observed, insufficient space to accommodate patient visitors, and inadequate toilet, washing and storage facilities. This was totally unacceptable.

It was found at the time of the unscheduled inspection, that the admitting specialist team was accountable and responsible for the care of admitted patients who were being accommodated on the corridor adjacent to the ED. The corridor was not considered as part of the ED but an independent area to house patients. Nursing care was provided by bank nursing staff, under the supervision of the ED Clinical Nurse Manager 3, with the ED clinical staff providing an emergency response should a patient's condition deteriorate. The Investigation Team was informed, in the case of a patient deteriorating, that the patient would be moved from the corridor back into the main ED.

6.1.4 Patient Waiting Times on the Corridor Adjacent to the ED

Cognisant that the corridor was viewed by the Hospital as a short-stay facility pending admission to an inpatient bed and was common practice, at the time of the inspection, waiting times for admitted patients awaiting transfer from the corridor adjacent to the ED to an inpatient bed ranged from 55 minutes to 83 hours. Patients waiting on the corridor had been admitted under a range of specialties which included medicine, respiratory, orthopaedics and gynaecology.

During the inspection and a review of patients' medical records, it was identified that the in-house teams reviewed their patients during ward rounds from early in the morning (7am) to mid-morning (10.30am). The Authority had concerns in relation to late ward rounds. However, in exploring this at interview, it was found that there was no ring-fencing of medical beds. Consequently, patients under the care of the same specialty team could be accommodated in multiple areas across the Hospital. It was reported at interview that clinical teams, particularly medical teams, prioritised their ward rounds to ensure that they reviewed the patients in order of their clinical need.

In practice, this meant, as evidenced on the morning of the unannounced inspection, that some patients on the corridor had not been reviewed until mid-morning by their team. Notwithstanding the above, it was reported at interview, and further evidenced in documentation that proactive patient discharge planning, to include early morning wards and timely clinical decisions, were not consistently supported by the range of clinical disciplines. This will be further discussed in Subsection 8.8.

The Authority believes that it is unacceptable for any patient to be accommodated in similar conditions in any hospital in Ireland and that it is unacceptable that such conditions could become an established part of the patient's care pathway. At a minimum, patients deserve that their privacy and dignity is respected and preserved, that there are appropriate levels of nursing and clinical cover available, and that there is the appropriate level of, and access to, clinical monitoring equipment.

6.2 Conclusions

Based on the information received prior to the unannounced inspection, and what was observed on the morning of the unannounced inspection, a number of issues were identified which the Authority believed to have the potential to pose serious risk to the health and welfare of persons receiving unscheduled acute care at the Hospital.

The Authority wrote to the Chief Executive of the Hospital on 25 August 2011 requiring the cessation of the use of the corridor adjacent to the ED by 1 September 2011. The Chief Executive confirmed to the Authority on 29 August 2011 that the use of the corridor adjacent to the ED for the accommodation of patients had ceased. (See Appendix 8)

The use of the corridor adjacent to the ED for admitted patients awaiting an inpatient bed should never have generally been considered as a suitable clinical area by managers, clinicians and Board members at the Hospital and should not have been operated as a clinical area, it has been reported that the Hospital has ceased the use of the corridor adjacent to the ED for the accommodation of admitted patients awaiting an inpatient bed. This will improve the quality

and safety of care for these types of patients. However, the Authority cautions that the accommodation of this patient group within the vicinity of the ED, or alternatively on trolleys on inpatient wards or corridors, may still fail to fulfil the minimum criteria that a patient should expect in a short-stay area pending transfer to an inpatient bed.

In addition, whilst in the ED, this patient group could inadvertently impact on the capacity of the ED to see and treat new patients in a timely and appropriate manner. It is important that all hospitals, the HSE and the SDU, monitor the bed management arrangements and potential risks, from a hospital-wide perspective, for admitted patients awaiting accommodation in an inpatient bed. Similar practices that were in operation at the Hospital at the outset of the investigation are not acceptable in any hospital.

7 National Emergency Department performance on 23 -24 August 2011

7.1 Introduction

Waiting times for patients in Ireland's emergency departments has been a longstanding concern from a patient safety, patient advocacy and service provider perspective. This came to the fore in 2007 when the Health Service Executive published the Emergency Department Task Force Report,⁽³²⁾ which contained a number of recommendations to be implemented across all EDs, which included:

- zero tolerance to patient trolley waits
- a strategy to implement a maximum six-hour waiting time from attendance to admission or discharge
- enhanced senior clinical decision making
- effective ED information systems with internal management controls
- timely patient discharge planning with supporting primary, community and continuing care response
- an appropriate ED avoidance by creating alternative care pathways to urgent care
- extended access to diagnostics for GPs and EDs.

Although this investigation focused on the Emergency Department (ED) and acute patient admissions process at the Hospital, the Authority felt that the national context had to be considered for patients receiving similar services across the country in order to compare the performance of the ED services in the Hospital with other hospitals in the same period. In addition, the Authority felt it appropriate to consider the national context for the benefit of national learning, and in order that the Authority might also, if appropriate, make national recommendations to promote and improve safety and quality in the provision of health services, for the benefit of the health and welfare of the public, as identified in the Terms of Reference.

Consequently, the Authority required the HSE to provide it with data for a 24-hour period, starting at 09:00 hours on 23 August 2011, to 08:59 hours on 24 August 2011, for all service providers in receipt of State funds, both statutory and voluntary (excluding AMNCH) providing emergency department services. The Authority requested that the HSE ensured that all the data was validated by service providers prior to its submission to the Authority and for the purpose of factual accuracy.

The Authority recognises that some national initiatives have been taken towards addressing the findings of the Task Force⁽³²⁾ which include:

- the HSE's Winter Initiative (2006 – 2009) which put in place a broad set of hospital and community initiatives with associated funding
- a National Full Capacity Protocol with associated individual hospital monitoring (2010)
- a National Discharge Planning Group (2008 – 2010)

However, the outstanding issue of extended waiting times for patients in Ireland's EDs remained, at the time of reporting, still to be resolved and historically, the means of measuring waiting times for patients in the ED was of poor quality and did not identify the true picture of patients waiting at any given time. Consequently, the Authority would question how the issue of extended waiting times can effectively be managed if the performance of ED's is not being properly or accurately measured.

7.2 Methodology

In order to gain the national picture of ED attendances for a 24-hour period, the Authority required the HSE to provide it with validated data for the 24-hour period, starting at 09:00 hours on 23 August 2011, for all service providers in receipt of State funds, both statutory and voluntary (excluding AMNCH) providing emergency department services. Excel workbooks were provided for data collation and the HSE were advised that the data was only required if available electronically and validated by the service provider.

The HSE coordinated the validated data submission for 33 hospitals providing various levels of emergency department services. No hospital was able to fully complete the data request. The HSE provided validated data for 24 hospitals. This validated data included the times of patient's registrations, discharges and admissions to an inpatient ward together with the patient outcome for each ED attendance.

Nine hospitals were unable to provide any data citing that the data was unavailable electronically. In these cases, the Authority required the HSE to provide activity data for the number of ED patient attendances and the number of patients admitted for the defined 24 hour period for each of the nine hospitals.

The HSE provided data for the time of patient triage for only 18 hospitals and data for time that patients were seen by ED clinicians for only 14 hospitals. Limited or no data was provided for the time of patient referral to the specialty team and time of decision to admit patients. The HSE provided additional information in relation to inpatient bed availability and number of delayed patient discharges per hospital for the defined 24 hour period.

A number of data integrity issues from the submitted data were identified when preparing the data for analysis, these included:

- missing outcome data to complete waiting time calculations
- incorrect date and time data format requiring reformatting by the Authority to support analysis
- inconsistency with the outcome related data.

Since the publication of the emergency department taskforce report in 2007, there has been a considerable national focus on ED services, in particular patient waiting times and the quality of services following the publication of the Task Force recommendations. Therefore, it is unacceptable that at the time of this investigation in 2011, the HSE and hospitals providing emergency department services on its behalf, still did not have adequate information gathering and analysis processes in place to performance manage their EDs from a patient experience and timeliness perspective. This information is a valuable resource for improving ED services and, most importantly, delivering a safe, well managed, quality service for patients. Service providers accountable for providing ED services cannot effectively manage the service for patients in the absence of this.

The Authority recognises that the national picture may have changed and improved since the August data analysis and the HSE, as a priority, should publicly report the findings on a periodic basis.

7.3 Attendance nationally and source of referrals

For the period in question, there were 3210 patient attendances nationally, of which 23% of people were admitted. Patient attendance and the source of referral data for each of the hospitals is illustrated below by HSE region (Table 10). Whilst in Subsection 5.2.1 the Authority noted that a referral pattern in the range of 20% of referrals being from GPs is not unusual, in the context of the data below, the reader will see a range of referral patterns. These variances can be interpreted as being indicative of a wide range of factors, including the location of the hospital, its catchment area and the availability of community services.

Table 10: Emergency Department Attendance and Referral Source by Hospital for 24-hour period, 24 August 2011

Hospital	Total number of ED attendances	ED admissions as a % of ED attendances	Self referrals %	Other %	GP Referrals %
Dublin Mid-Leinster HSE Region					
AMNCH	117	28%	69%	14%	17%
Mullingar/MRHM	82	16%	N/A [†]	N/A	N/A
Naas	59	39%	51%	3%	46%
Portlaoise/MRHP	142	13%	56%	24%	20%
St Columcille's	34	56%	N/A	N/A	N/A
St James's	134	27%	60%	7%	33%
St Michael's	40	5%	75%	10%	15%
St Vincent's	119	21%	50%	26%	24%
Tullamore/MRH	90	22%	45%	1%	54%
Dublin North East HSE Region					
Cavan	85	22%	55%	12%	33%
Drogheda/OLLHD	158	27%	54%	10%	35%
Navan/OLHN	50	10%	64%	-	36%
Beaumont	150	25%	53%	7%	40%
Connolly**	191	20%	N/A	N/A	N/A
Mater	142	22%	64%	11%	25%
South HSE Region					
Bantry	9	33%	11%	-	89%
CUH	166	34%	27%	15%	58%
Mallow	56	11%	39%	-	61%
Kerry	68	24%	53%		47%
Mercy	69	13%	58%	10%	32%
South Infirmary Victoria	71	13%	37%	44%	19%
South Tipperary	73	25%	62%	4%	34%
St Luke's Kilkenny	61	11%	52%	5%	43%
Waterford	169	20%	41%	22%	37%
Wexford	86	29%	80%	2%	18%

West HSE Region					
Galway	174	10%	41%	2%	57%
Portiuncula	60	20%	28%	32%	40%
MWRH Limerick	154	27%	N/A	48%	52%
Ennis	36	25%	N/A	N/A	N/A
Nenagh	33	25%	N/A	N/A	N/A
Letterkenny	102	25%	41%	10%	49%
Mayo	92	29%	40%	2%	58%
Sligo	79	25%	42%	14%	44%
St John's Limerick	59	15%	51%	5%	44%
† N/A – denotes data not available electronically					
** Connolly Hospital – data provided for 24-hour period from 00:00 – 00:59 hours on 23 August 2011					

Source data: HSE

7.4 Timeliness of ED admissions

National and international best practice recommends a target of 95% of patients being admitted (where appropriate) within six hours of arrival to the ED of a hospital, with 100% being admitted within nine hours.^(18,19) As is evidenced in the below table (Table 11), and despite the recommendations and initiatives undertaken as a result of the HSE ED Task Force report in 2007,⁽³²⁾ the vast majority of EDs in Ireland still failed to meet this target in August 2011. In practice, this means that despite well publicised initiatives and strategies, patients continue to wait for unacceptably long periods in EDs in Ireland and, as a result, are potentially exposed to higher levels of risk than is necessary.

Table 11: Timeliness of Emergency Department (ED) Admissions by Hospital (Total Time in ED (TEDT) target: 95% within 6 hours / 100% within 9 hours of arrival in ED) on 24 August 2011

Hospital	Median time from ED Registration to admission to ward (hh:mm)	Longest time from ED Registration to admission to ward (hh:mm)	% admitted within 6 hours of ED attendance (Time from registration to admission)	Number of admitted patients who remained in ED until discharge	Number of admitted patients in ED greater than 24 hours (from time of Registration)
Dublin Mid-Leinster HSE Region					
AMNCH	14:13	25:53	17%	N/A [†]	1
Mullingar/MRHM	N/A	N/A	N/A	N/A	N/A
Naas	15:24	66:47	9%	2	4
Portlaoise/MRHP	N/A	N/A	N/A	N/A	N/A
St Columcille's	N/A	N/A	N/A	N/A	N/A
St James's	8:51	24:54	19%	0	1
St Michael's	5:46	6:03	50%	0	0
St Vincent's	11:01	42:24	16%	1	7
Tullamore/MRH	6:52	25:56	45%	0	2
Dublin North East HSE Region					
Cavan	20:23	25:52	25%	2	5
Drogheda/OLLHD	18:43	73:35	16%	7	14
Navan/OLHN	N/A	N/A	N/A	N/A	N/A
Beaumont	16:27	40:52	14%	0	11
Connolly	N/A	N/A	N/A	N/A	N/A
Mater	19:15	38:32	6%	0	14
South HSE Region					
Bantry	1:30	7:22	67%	0	0
CUH	16:45	48:53	38%	0	13
Mallow	1:43	3:30	100%	0	0
Kerry	3:52	11:44	63%	0	0
Mercy	4:45	15:25	56%	0	0
South Infirmary Victoria	5:04	22:29	56%	0	0
South Tipperary	3:32	10:05	89%	0	0
St Luke's Kilkenny	5:50	10:25	57%	0	0
Waterford	9:53	19:54	24%	0	0
Wexford	N/A	N/A	N/A	N/A	N/A

West HSE Region					
Galway	10:29	69:45	18%	9	2
Portiuncula	4:58	137:48	67%	0	1
MWRH Limerick	10:08	26:41	38%	0	3
Ennis	N/A	N/A	N/A	N/A	N/A
Nenagh	N/A	N/A	N/A	N/A	N/A
Letterkenny	6:55	20:16	45%	2	0
Mayo	4:10	11:01	85%	0	0
Sligo	N/A	N/A	N/A	N/A	N/A
St John's Limerick	6:08	7:53	33%	0	0

† N/A – denotes data not available electronically

Source data: HSE

The Authority acknowledges that at the time of the investigation, a national performance management initiative had begun under the auspices of the SDU, at eight hospitals to address this challenge.⁽¹⁴⁾ At the time of reporting, the SDU confirmed that support mechanisms had been extended to all hospitals providing ED services in Ireland. The SDU should ensure that all initiatives taken are monitored for both an immediate and long-term impact. The necessary supports and controls should be put in place to ensure that initiatives are sustainable and serve to improve the quality and safety of services across all hospitals providing emergency care. In doing so, it is critical that a national suite of composite performance measurements are introduced in order for managers and clinicians to measure the totality of the patient journey actively and prevent any unintended consequences which could adversely impact the wider group of patients attending for scheduled and unscheduled care in hospitals in Ireland.

7.5 Total time in ED for discharged patients

The following tables demonstrate the timeliness of ED attendances for patients who attend, and are subsequently discharged from the ED (Table 12). Whilst the data illustrates that a greater number of hospitals were achieving, or were close to achieving, the target of 95% of patients being seen and discharged (as appropriate) within six hours of attending the ED, the target was not being consistently met across all EDs. The Authority recognises that at the time of reporting, work was underway by the SDU at a number of hospitals, and this must ensure the sustainability and long-term impact of any changes implemented.⁽¹⁴⁾

Table 12: Timeliness of ED attendances discharged directly from ED by Hospital (Total Time in ED (TTED) target: 95% within 6 hours/ 100% within 9 hours of arrival in ED) – 24 August 2011

Hospital	Median time from ED Registration to discharge from ED (hh:mm)	Longest time from ED Registration to discharge from ED (hh:mm)	% of ED attendances discharged from ED within 6 hours of time of registration
Dublin Mid-Leinster HSE Region			
AMNCH	6:53	22:36	43%
Mullingar/MRHM	N/A [†]	N/A	N/A
Naas	6:39	21:19	42%
Portlaoise/MRHP	N/A	N/A	N/A
St Columcille's	N/A	N/A	N/A
St James's	3:59	15:47	72%
St Michael's	1:03	4:53	100%
St Vincent's	3:20	24:39	81%
Tullamore/MRH	2:12	25:02	97%
Dublin North East HSE Region			
Cavan	1:36	26:34	91%
Drogheda/OLLHD	2:42	75:51	77%
Navan/OLHN	N/A	N/A	N/A
Beaumont	5:45	28:26	56%
Connolly	N/A	N/A	N/A
Mater	2:30	50:11	73%
South HSE Region			
Bantry	1:05	2:45	100%
CUH	4:02	38:51	71%
Mallow	1:25	5:25	100%
Kerry	1:48	5:43	100%
Mercy	3:31	100:33	83%
South Infirmary Victoria	2:49	21:01	69%
South Tipperary	1:57	8:34	95%
St Luke's Kilkenny	3:11	8:25	98%
Waterford	2:49	24:13	90%
Wexford	N/A	N/A	N/A

West HSE Region			
Galway	5:38	91:52	52%
Portiuncula	2:31	6:39	98%
MWRH Limerick	2:20	29:07	82%
Ennis	N/A	N/A	N/A
Nenagh	N/A	N/A	N/A
Letterkenny	2:39	12:38	91%
Mayo	2:42	115:49	91%
Sligo	N/A	N/A	N/A
St John's Limerick	2:35	7:45	96%
† N/A – denotes data not available electronically.			

Source data: HSE

7.6 Inpatient bed capacity

Information was requested through the HSE for all statutory and voluntary hospitals providing emergency department services (n=33), which included the total number of inpatient beds and the number of inpatient beds open and closed during the 24 hour period from 09:00 hours on 23 August to 08:59 hours on 24 August 2011 (Table 13). The bed numbers reported by each hospital were dependent on the services provided which included adult, paediatric and obstetric services. The number of psychiatric beds was excluded.

Approximately 8803 inpatient beds were open during the defined period with 611 beds reported as 'closed'. The HSE defines a closed bed as a bed temporarily out of use and which is part of the bed complement, but is not available for inpatient or day case care due to the following reasons: a) cost containment b) infection control c) refurbishment/ maintenance d) seasonal closures e) other (for example, theatre capacity, staff shortages).

Of the 34 hospitals (33 hospitals plus AMNCH), 25 hospitals reported a number of bed closures ranging from 1 to 66 beds closed. No bed closures were reported at nine hospitals.

Table 13: Total number of inpatient beds, number of beds open and closed during the defined 24-hour period – 24 August 2011

Hospital	Total number of inpatient beds	Number of beds open during defined 24-hour period	Number of Bed closed during defined 24-hour period
Dublin Mid Leinster HSE Region			
AMNCH	448	419	29
Mullingar [▽] / MRH	172	178	0
Naas	155	124	31
Portlaoise / MRH	140	131	9
St Columcille's	106	102	4
St James's	797	780	17
St Michael's	122	95	27
St Vincent's	443	431	12
Tullamore / MRH	226	199	27
Dublin North East HSE Region			
Cavan	190	190	0
Drogheda /OLLHD	354	326	28
Navan [▶] / OLHN	97	127	0
Beaumont	668	603	65
Connolly	205	181	24
Mater	518	516	2
South HSE Region			
Bantry	72	62	10
CUH	585	585	0
Mallow	66	66	0
Kerry	284	284	0
Mercy	227	190	37
South Infirmary Victoria	196	142	0
South Tipperary	168	167	1
St Luke's Kilkenny	249	200	49
Waterford	389	384	5
Wexford	205	181	24

West HSE Region			
Galway	647	609	38
Portiuncula	162	149	13
MWRH Limerick ^Σ	383	354	36
Ennis	55	56	0
Nenagh	52	52	0
Letterkenny ^π	302	332	18
Mayo	273	273	15
Sligo	318	246	66
St John's Limerick	93	69	24

▽ *No bed closures were reported at Midlands Regional Hospital, Mullingar, however, the hospital reported extra beds on inpatient wards (n=6 extra beds) during the identified 24-hour period.*

► *No bed closures were reported at Navan General Hospital, however, the hospital reported extra beds on inpatient wards (n=30 extra beds) during the identified 24-hour period.*

Σ *Although the Mid-Western Regional Hospital Limerick reported a number of beds closures during the defined period, the Hospital also reported a number of extra beds (n=7) on inpatient wards at that time.*

π *While Letterkenny General Hospital reported that a number of beds were closed during the defined period, it also reported a number of extra beds (n=30) on inpatient wards during that time.*

Source data: HSE

A reduction in the inpatient bed capacity as a result of bed closures may, if not effectively managed, potentially have a serious adverse impact on the timeliness of scheduled and unscheduled patient care.

7.7 Delayed patient discharges

Information was requested through the HSE for all statutory and voluntary hospitals providing emergency department services (n=33), which included the total number of delayed discharges during the 24 hour period from 09:00 hours on the 23 to 08:59 hours 24 August 2011. A Delayed Patient Discharge is defined as a patient who has completed the acute phase of his/her care and is medically fit for discharge into a non-acute setting.⁽³³⁾

The number of patients is counted from the first day of the delayed discharge and each hospital conducts a weekly census of the number of patients identified as a delayed discharge. Delayed discharges are nationally categorised by patients

65 years and over requiring long-term care placement or as identified by each hospital and by patients under 65 years of age.⁽³³⁾ This data was not available for one hospital.

A total of 799 delayed patient discharges were reported by the 32 hospitals and the Hospital (as at June 2011). 89% (n=712) were categorised as patients 65 years and over, with 11% (n=87) categorised as patients under 65 years of age. Table 14 below illustrates the number of delayed patient discharges for 65 years and over and under 65 years by hospital as well as the related percentage against the available number of beds at each hospital.

In relation to the delayed patient discharges categorised as patients 65 years and over, all hospitals except one recorded a number of delayed discharges ranging from 1 to 116 with an average of 22. The highest number of delayed discharges were recorded by Dublin Academic Teaching Hospital, St James's Hospital (n=116), Beaumont Hospital (n=70), Mater Misericordiae University Hospital (n=67), AMNCH (n=67) and St Vincent's University Hospital (n=53).

In relation to the delayed patient discharges categorised as patients under 65 years, 17 hospitals recorded a number of delayed discharges ranging from 1 to 16 with an average of 5. The highest number of delayed discharges were recorded by the Mater Misericordiae University Hospital (n=16) and Beaumont Hospital (n=16).

Hospitals reported the main reasons for delayed discharges as relating to the Nursing Homes Support Scheme^(34,35) – a Fair Deal[‡] (such as processing an application or awaiting funding decisions), access to suitable long-term care service dependent on patient needs, availability of intermediate, convalescence and hospice beds, availability of community support (such as home care or home adaptations), access to rehabilitation services including the National Rehabilitation Hospital and awaiting Ward of Court hearings. This is further discussed in section 8.8.4.

‡ The Nursing Homes Support Scheme Act 2009, a Fair Deal, is the financial support scheme available for people who require long-term nursing home care. Under this scheme, the State may contribute towards some of the cost of long term nursing home care. Applications for Fair Deal are made through the HSE Nursing Homes Support Offices and involves the assessment of the patients care needs and finances to ascertain patients contributions to the cost.

Table 14: Number of delayed discharges for patients 65 years and over and patients under 65 by hospital and the related percentage of open beds for the defined 24-hour period of 24 August 2011

Hospital	65 and over delayed discharges	Under 65 delayed discharges	Number of open beds for the defined 24-hour period	Delayed discharges as a % of available beds (open)
Dublin Mid Leinster HSE Region				
AMNCH	60	7	419	16%
Mullingar / MRHM	7		178	4%
Naas	9	2	124	9%
Portlaoise / MRHP	11		131	8%
St Columcille's	18	2	102	20%
St James's	116	5	780	16%
St Michael's	12		95	13%
St Vincent's	53	7	431	14%
Tullamore / MRH	16		199	8%
Dublin North East HSE Region				
Cavan	11		190	6%
Drogheda	27	5	326	10%
Navan	3		127	2%
Beaumont	70	11	603	13%
Connolly	46	7	181	29%
Mater	67	16	516	16%
South HSE Region				
Bantry	12		62	19%
CUH	26	7	585	6%
Mallow	7		66	11%
Kerry	2		284	1%
Mercy	8		190	4%
South Infirmary Victoria	N/A	N/A	142	0%
South Tipperary	2	1	167	2%
St Luke's	18		200	9%
Waterford	27	4	384	8%
Wexford	26	2	181	15%

West HSE Region				
Galway	27	2	609	5%
Portiuncula	3	1	149	3%
MWRH Limerick	10	7	354	5%
Ennis	0		56	0%
Nenagh	2	1	52	6%
Letterkenny	4		332	1%
Mayo	1		273	0%
Sligo	5		246	2%
St John's Limerick	6		69	9%

Source data: HSE

7.8 Conclusions

Waiting times for patients in Ireland's emergency departments has been a longstanding concern from a patient safety and quality, patient advocacy and service provider perspective. This came to the fore in 2007 when the HSE published the Emergency Department Task Force Report, which contained a number of recommendations to be implemented across all emergency departments (ED) in Ireland.

The Authority reviewed the national data submitted and validated by the HSE of ED patient attendance for one day – 24 August 2011. Whilst the data returned was not consistent in the level of detail provided by all 33 hospitals, the Authority is concerned with the overall waiting times recorded for patients pending admission or discharge. Internationally, clinical quality indicators identify that excessive waiting times from patient registration to admission or discharge can be linked to poor patient outcomes.^(19,36) The data recorded by the HSE for that day tends to show that patients attending the majority of EDs in Ireland experience waiting times of greater than six hours, with the longest waiting times being of up to 115.49 hours for discharge and 137.48 hours for admission.

A total of 799 delayed patient discharges were reported by the 32 hospitals and AMNCH, Tallaght (as at June 2011). 89% were categorised as patients 65 years and over, with 11% categorised as patients under 65 years of age. Hospitals reported the main reasons for delayed discharges as relating to the Nursing Homes Support Scheme – A Fair Deal, access to suitable long-term care service dependent on patient needs, availability of intermediate convalescence and hospice beds, availability of community support and access to rehabilitation services.

It is not acceptable that in 2011, when this data was sought, the HSE and hospitals providing emergency department services on its behalf still did not have adequate information gathering and analysis processes in place to performance

manage their EDs from a patient experience and timeliness perspective. Services providers accountable for providing ED services cannot effectively manage and improve services for patients in the absence of this.

The findings identified potential risks to patients associated with long waiting times in an ED and also an absence or lack of available data. This suggests that the system of care is not being as actively managed as it should be. In view of the serious nature of these risks, the Authority wrote to the then Secretary General of the Department of Health on 1 February 2012 and requested that the Special Delivery Unit, in its capacity of performance managing ED wait times, review and address these issues as a matter of priority (see Appendix 9).

Recommendations – Unscheduled Care

Emergency Department Services

1. The Hospital's operational and executive management structures, with the assistance of the National Emergency Medicine Programme (NEMP), should have the necessary arrangements in place to implement the NEMP. The executive must provide periodic assurances to the Board of the Hospital regarding the quality, safety and timeliness of unscheduled patient care delivered at the Hospital.
2. The Hospital should have effective arrangements in place to manage and monitor the utilisation of the Clinical Decision Unit in order to ensure that the length-of-stay timeline for patients is less than 24 hours.
3. Every hospital should cease the use of any inappropriate space (for example, a hospital corridor or a parking area for trolleys) to accommodate patients receiving clinical care.
4. All hospitals providing an emergency department service should undertake a periodic analysis of the types and profiles of patients who re-attend or leave without being seen and the underlying causes for re-attendance. Any potential improvements identified as a result should be implemented and evaluated. Using this data, the HSE should set national key performance indicators (KPIs). These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar casemix.
5. All hospitals providing emergency care must continually manage and review the effectiveness of the patient-streaming, patient discharge arrangements, access to diagnostic investigations and fast-tracking systems in place.

6. The working hours and availability of emergency medicine consultants and senior clinical decision makers should be reviewed and amended in line with the objectives and recommendations of the National Emergency Medicine Programme.
7. The Manchester Triage System must be implemented, managed and periodically evaluated to ensure that it is being applied effectively in all hospitals.
8. The National Early Warning Score (NEWS) should be implemented in all clinical areas providing inpatient care. An emergency department specific system of physiological monitoring and triggered responses comparable to the NEWS should be implemented.
9. The involvement of general practitioners nationally in emergency departments, currently a reality in only a minority of hospitals, should be further enhanced and established on a formalised basis in partnership with primary care in all acute hospitals providing 24/7 care.
10. The working hours and availability of consultants on call in other emergency service areas in acute hospitals, such as acute medical units, should also be reviewed and amended where necessary.

Clinical Governance

11. All hospitals must have the necessary arrangements in place to ensure that there is a named consultant clinically responsible and accountable for a patient's care at all points in the patient journey and throughout their hospital stay.
12. All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that on-call clinical teams are available to see patients in the emergency department.
13. The Health Service Executive should review the current national position of the expanded roles within nursing and allied health professionals and implement a plan to roll out a more extensive programme of expanded practitioners within the appropriate clinical settings and with the necessary clinical governance arrangements in place nationally and locally.

Managing Performance and Information

14. The total patient time spent in the emergency department should be less than six hours. This time should be measured from the time the patient arrives in the ED to the time of departure from the ED. These KPIs should be monitored, managed and reported publicly and include benchmarking against EDs with a similar casemix

- 15.** National data pertaining to the quality, safety and timeliness for patients in all hospitals providing emergency department services should be monitored and published at local, regional and national level.
- 16.** The HSE, in conjunction with the Special Delivery Unit, should develop, monitor and publish a suite of composite quality, safety and access indicators measuring key points throughout the totality of unscheduled and scheduled patient care.
- 17.** All hospitals in Ireland should monitor the implementation of the National Ambulance Patient Handover Time in line with the National Emergency Medicine Programme which requires 95% of patients being handed over from an ambulance crew to the emergency department staff in less than 20 minutes, and where this is not met, corrective action should be taken.

8 Scheduled Care

Within this section, the report will describe the Authority's findings in relation to the current arrangements for the provision of scheduled clinical care in the Hospital, how scheduled care services should be provided in line with best practice and the recommendations for improvement by the Authority, both specifically in relation to the Hospital and nationally for the purpose of wider system learning and the promotion generally of safety and quality in the provision of health services for the benefit of the health and welfare of the public.

8.1 Introduction

Scheduled care describes the care which patients receive on a planned basis. Scheduled care includes for example, receiving care as an outpatient or being admitted for a scheduled surgical procedure or a diagnostic test. Scheduled care is provided to patients either as a day case or as an inpatient.

As outlined in Chapter 5, it is important to note that the effectiveness with which a hospital manages patients who require scheduled care for a booked or elective purpose (for example, patients booked for planned surgical procedures) is directly related to the effectiveness with which it manages patients who require unscheduled care and admission. The two admission and discharge processes are interdependent on each other.

Effective and efficient hospital services for patients can only be achieved when both of these patient admission processes are actively managed together - in recognition of the relationship and interdependence of the two, and in partnership with other key stakeholders in the community.

Scheduled care is dependent on patients being assessed and cared for in the right place, by the right level of clinical decision-maker daily, with prompt access to diagnostic results and for the optimum duration. The optimum duration involves scheduled patients only being admitted for the minimum safe period required, discharge planning beginning on the day of admission and the hospital actively designing systems to ensure a continual patient flow through the hospital to avoid patients being 'backed-up' in inappropriate areas, for example, the Emergency Department with the resulting risks that may arise.⁽³⁷⁾

8.2 National initiatives in scheduled care

Nationally, the Acute Hospital Bed Capacity Review⁽³⁸⁾ identified in 2007 that 75% of scheduled surgical patients were admitted to acute hospitals in Ireland earlier than necessary. This potentially means that there is scope for acute hospitals to review their current practices, streamline their services to maximise bed availability and reduce patient's length of stay in hospital. The National Clinical Care Elective Surgery Programme currently in development, aims to provide a guide for developing Integrated Care pathways to include:

- a pre-admission assessment
- the same day of surgery admission
- effective discharge planning
- an active surgical audit programme
- a productive operating theatre programme.

During the course of the investigation, the HSE reported that components of a National Surgical Care Programme were being implemented at the Hospital. For example:

- expanded pre-assessment clinics
- the review and development of surgical bed and surgical specialty ring-fenced bed activity plans
- the development of a local surgical care governance implementation group.

The HSE had also implemented a number of other initiatives in the area of scheduled care including an Out Patient Department (OPD) Service Improvement Project and the establishment of a Discharge Planning Group. In addition, a National Director of Performance Improvement in Scheduled Care was appointed to the SDU in December 2011.

8.3 Scheduled care at the Hospital

In the Hospital, a suite of internal key performance indicators (KPIs) and nationally reported KPIs were provided to the Transitional Board of the Hospital each month for information and analysis. These included, for example, the:

- average length of stay per specialty
- adult inpatient waiting list
- Outpatient Department 'did not attend' rates
- delayed patient discharge rates
- HealthStat hospital reports.

Based on data submitted by the Hospital, of the total number of patient admissions in 2010, scheduled care accounted for approximately 17% of total

inpatient admissions. On review of the cancellation of adult scheduled inpatient admissions, from January to August 2011, a total of 1489 patients were cancelled. Of those, 41% (n=613) were cancelled by the Hospital, 37% (n=545) by patients consultants and 22% (n=331) by the patients themselves.

Table 15 illustrates the total number of patients admitted as inpatients or as day cases and the total number of patients who attended the Out Patient Department (OPD) in 2010 and from January to June 2011.

Table 15: Number of patients discharged from inpatient and day case services in the Hospital in 2010 and from January to June 2011

Adult elective inpatient discharges	Number of patients in 2010	Number of patients from January to June 2011
Public	1,795 (69%)	1,010 (73%)
Private	807 (33%)	375 (27%)
Total	2,602	1,385
Adult day case attendances		
Public	19,716 (68%)	14,319 (70%)
Private	9175 (32%)	6017 (30%)
Total	28,891	20,336

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

8.3.1 Outpatient services

For the majority of patients the first entry point for scheduled care is when their General Practitioner (GP) or a hospital specialist refers them for specialist consultation in the Outpatient Department (OPD). At the time of the investigation, the Hospital provided a wide range of adult outpatient services including:

- Anesthesia Paediatrics Anaesthesia
- Pain Management
- Anaesthesia Adults (including ICU)
- Cardiology
- Dermatology
- Emergency Medicine
- Endocrinology / Diabetes
- Gastroenterology
- General (Internal Medicine)
- Acute Care of the Older Person
- Medical Oncology

- Nephrology and Renal Dialysis
- Neurology
- Neurophysiology
- Palliative Medicine
- Rehabilitation Medicine
- Rheumatology
- Paediatric Community Child Health
- Paediatric Emergency Medicine
- Paediatric Endocrinology
- Paediatric Gastroenterology
- Paediatric Neurology
- Paediatric General Medicine
- Paediatric General Surgery
- Paediatric Respiratory Medicine
- Paediatric Orthopaedics
- Paediatric ENT
- Paediatric Cardiology
- Pathology
- Child and Adolescent Psychiatry
- General Adult Psychiatry
- Liaison Psychiatry
- Older Person Psychiatry
- Radiology
- Gastrointestinal Surgery
- Gynaecology
- Ophthalmology
- Orthopaedics – Trauma & Elective
- Otolaryngology (ENT)
- Urology
- Vascular Surgery

In 2009 and 2010, a series of engagements took place between the Authority and the Hospital regarding ongoing concerns in relation to the governance and quality and safety arrangements at the Hospital. During this time, the Hospital came under review by the Hayes Report,⁽²⁾ which included a review of unprocessed GP patient referral letters to the OPD.

The Investigation Team requested an update from the HSE and the Hospital as to the implementation of the recommendations of the Hayes Report.⁽²⁾

The HSE conducted an audit of the implementation of the outpatient recommendations of the Hayes Report in October 2011. This audit, in addition to documentation provided by the Hospital, demonstrated that new policies and procedures had been developed and were in operation to support the efficient processing of GP patient referrals in the OPD. It was also reported at interview that the Hospital OPD was discussed at regular meetings at a regional HSE level. The HSE audit found that there was ongoing engagement with GPs and other relevant external stakeholders which included the consultant staff and medical secretaries in relation to the operation of the OPD at the Hospital. However, having considered the information provided at interview and the documentation and data submitted, the Authority was not assured that mutual understanding, co-operation and support in relation to the implementation of the revised referral process had been established with all GPs in the Hospital catchment area. To ensure the successful implementation of these new initiatives, the Hospital must

effectively engage with the key stakeholders. Work was ongoing at the time of the investigation to improve the processes in the OPD. However, the Authority was unable to assess the full impact of these initiatives.

In addition to addressing the recommendations of the Hayes Report, the Director of Performance and Planning at the Hospital had responsibility for the Out Patient Turnaround Project as part of a Quality Improvement Plan for the Hospital. The Hospital reported that a number of initiatives were in place which included:

- OPD waiting lists being migrated to electronic waiting lists
- the Hospital being the national lead site for the automation of OPD registration for patients
- the Hospital being a pilot site for the national GP electronic referral programme
- the Hospital implementing the involvement of its OPD Governance and Operational Committee with the HSE in the development of a national OPD policy and procedure.

During the course of this investigation, the Authority was unable to assess the full impact of these initiatives.

8.3.2 Outpatient Referrals

Patients attending the outpatient department may be new patient referrals or patients who are attending for review following discharge from hospital or had previously attended the OPD. New patients are primarily referred to the outpatient department by their general practitioner (GPs) for a specialist consultation.

Table 16: Outpatient Department appointment and attendance activity - January to July 2011

Outpatient Department Activity	2011							
	January	February	March	April	May	June	July	Total
Outpatient appointments issued	26067	24918	27472	23506	26963	25129	24041	178096
Number of outpatient attendances	21931	21214	23306	19931	22469	21164	20139	150154
Did Not Attend	4136	3704	4166	3575	4494	3965	3902	27942

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

For the period between January and July 2011, the Hospital issued 178,096 outpatient appointments. However, 27,942 (16%) patients were recorded as having not attended for their appointment. These would be classified as patients who 'did not attend' (DNA). A patient not attending for their scheduled appointment represents a serious challenge to the efficient operation of an outpatient department and further reduces access for other patients awaiting an appointment. It is the responsibility of patients to inform the Out Patient department when they are not attending for their scheduled appointment. It was reported at interview, and further evidenced in documentation received, that the Hospital had identified the need to improve the DNA reminder process. However, an audit of the efficacy of this initiative was not available at the time of the investigation.

8.3.3 Outpatient Waiting Lists

Outpatient waiting time is defined as the time from GP patient referral to an appointment with a consultant. Nationally, the length of time patients are waiting for an OPD is reported as being unacceptably long in many specialties.⁽³⁹⁾ At the time of the investigation, the national target waiting time for an OPD appointment was 3 months. National data for OPD waiting times was not publicly available at the time of the publication of this report with OPD waiting times being a 2012 target to be addressed by the Special Delivery Unit within the Department of Health.⁽¹⁴⁾

In June 2011, 48% of patients in the Hospital were waiting less than 3 months for an OPD appointment with 52% waiting beyond the 90 day target. Excessive wait times for outpatient appointments can result in GPs referring patients or patients self referring through alternative pathways in order to access care. The most likely alternative pathway is for patients to be referred to the ED of a hospital. In tackling the issue of overcrowding and excessive demand on Emergency Department services, timely access to outpatient services is essential. The Authority noted that an Outpatients Turnaround Project was in progress at the Hospital at the time of the investigation which included addressing the issue of waiting lists. It was reported at interview that the OPD orthopaedic waiting lists had been reduced. However, at the time of the investigation, the impact of this project on the totality of wait times for the OPD could not yet be determined. Monitoring of the wait times for the OPD at the Hospital should be considered as a key indicator as to the impact of the OPD turnaround programme.

8.4 Diagnostic testing

Timely access to diagnostic testing such as X-rays, computed tomography (CT) scans or blood tests, is a crucial component in delivering an effective, timely and safe service to patients. Diagnostic tests serve to inform the most appropriate care and treatment for a patient.

8.4.1 Laboratory Services

At the time of the investigation, the laboratory services at the Hospital had nine consultants in post. This included four Consultant Histopathologists, 2 Microbiologists, 2 Haematologists and 1 Chemical Pathologist. 140 scientists supported the laboratory services. It was found that the turnaround times for diagnostics from the laboratory were generally good. However, there were time delays reported in sending the specimens to the laboratory, and these delays were attributed to the lack of integrated IT systems. It was reported at interview by the Hospital staff that this integration was underway.

During the course of the investigation, it was raised that the Microbiology department of the laboratory services had lost its accreditation due to infrastructure non-conformance. Re-accreditation for this department was reported to be in progress.

8.4.2 Imaging Services

In 2010, the imaging services at the Hospital were subject to review under the Hayes Report. At the commencement of the investigation, the Hayes Report radiology recommendations were under review with the Hospital reporting the national guidelines on radiology were implemented, two additional consultant radiology posts had been advertised, 75% of radiology data had been transferred to an upgraded system and a submission to further upgrade the information management systems had been sought from the HSE.

At the time of the investigation, the Imaging Department had 7.5 consultant radiologists in post (three of whom had a special interest in interventional radiology), 2 paediatric imaging consultants and 65 radiographers. The imaging department had one multi-slice Computed Tomography (CT) scanner and one Magnetic Resonance Imaging (MRI) scanner. The practice of radiographers reporting films was not in place. This is not uncommon in the national context. However, this expanded role should be considered, safely and appropriately, in the national context of maximising available resources across the system.

8.4.3 Out-of-hours Access to Diagnostic Imaging

For the purpose of this report, out of hours is defined as hours outside of the historical core hours of Monday to Friday and between 09:00 and 17:00 hours. At the time of the investigation, it was found that discussions were ongoing at a national level in relation to extending the working hours of the service to between 08:00 and 20:00 hours.

Over the period of January to July 2011, it was recorded by the Hospital that on average, 65% of the adult emergency department diagnostic imaging procedures were conducted out of hours. In considering this volume of diagnostic imaging requested out of hours, the issue of extended working hours within the imaging department should be addressed as a matter of priority.

8.4.4 Waiting Times for Access to Diagnostic Imaging

In the case of adult inpatient and adult emergency procedures, there was no waiting list recorded for either inpatient or emergency department patients awaiting diagnostic imaging. However, it was reported at interview, and noted during observation, that there were, for example, patients waiting for over 24 hours in the Clinical Decision Unit for CT scans and over 72 hours on a short-stay ward for MRI.

To help reduce the ED patient waiting times for diagnostic imaging it was reported at interview, and referenced in documentation, that some diagnostic imaging had been outsourced to a third party provider to reduce waiting lists. More recently, the Bed Management Group at the Hospital had set up new admission avoidance Diagnostic Imaging appointment slots for ED patients requiring tests. As this initiative had only been introduced it was not possible at the time of reporting for the Authority to assess the effectiveness of this.

Adult outpatients may be referred to receive additional diagnostics, such as abdominal ultrasound, CT and MRI. At the time of the investigation, no electronic requesting system was deployed at the Hospital and it was found that the system in place could not fairly reflect actual waiting times for patients referred to receive additional diagnostics.

It was reported that the outsourcing initiatives had reduced the waiting time for ultrasound to approximately eight weeks by the end of 2011. The Authority itself did not verify this information. However, it was also reported at interview that patients seen in the outpatient department could be waiting up to nine months for a CT scan or MRI.

Excessive wait times for diagnostics may result in patients not receiving optimum and timely care for their condition with the risk of further associated complications if there are undue delays in their diagnosis and any subsequent intervention that may be required. Excessive waiting times can also result in GPs referring or patients self-sourcing alternative pathways. It was found that excessive wait times for GP requested outpatient appointments for diagnostic imaging could result in patients being re-directed to the Emergency Department by their GP, or patients self-accessing alternative pathways.

This was further evidenced during the unannounced inspection that took place on 24 August 2011, where it was found that a patient who had attended the ED was admitted to the Hospital specifically for an inpatient MRI because the waiting time for an outpatient appointment was too great. This is a sign of a flawed system. At interview, the Authority explored this practice, and it was found that the excessive outpatient waiting times contributed to the challenge in avoiding admissions and reducing the length of stay for patients.

The Hospital should ensure that the robust, effective prioritisation of need for diagnostic imaging is in place for all patients. It was reported at interview that prioritisation is often informal, rather than through a formal structured process.

This potentially could lead to variances in the care being provided and contribute to unnecessary risks to patients.

In the context of the excessive waiting times for access to diagnostic imaging and the back log of requests, which were reported at interview to be up to 9 months, the Authority was concerned that these waiting lists had not been formally reviewed and that patients had not been prioritised in relation to their urgency and acuity which could potentially mean that patients with a serious illness could have a delay in their diagnosis and treatment and could potentially deteriorate further overtime.

8.4.5 Turnaround Times for Diagnostic Imaging Reports

For the purpose of this report, the turnaround time for a diagnostic imaging report, as reported by the Hospital, is defined from the time a patient registers in the department to the transmission of a printed report. It was found that in the case of diagnostic imaging reports for inpatients, a provisional report is available immediately.

Table 17 below illustrates the mean reporting turnaround time (days) for adult inpatients. It was reported at interview that the resource availability, from both a staff and equipment perspective, the outdated Picture Archiving and Communication system (PACS) and the lack of voice recognition technology contributed to significant challenges in providing timely access to, and reporting of, imaging diagnostic tests. These challenges were highlighted as areas to be addressed by the Hayes Report in 2010. However, at the time of the investigation, these issues had not been resolved fully.

Table 17: Diagnostic Imaging mean report turnaround time (days) for adult inpatients – January to July 2011

Diagnostic Imaging Test/ Procedures	2011							
	January	February	March	April	May	June	July	Mean
MRI	3.4	4.6	3.8	4	4	5.4	4.8	4
Ultrasound (U/S)	5.1	6.1	5.7	8	5.1	9.4	11.4	7
CT	3.6	4.7	4.7	5.6	5.5	6.3	6.9	5
Plain X-ray Film	4.3	4.6	9.3	6.4	9.3	11.9	8.9	8
Interventional Procedures	6.2	10.5	12.9	12.2	12.3	11.1	7.8	10

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

To ensure that patients receive the most appropriate diagnostic and therapeutic care it is imperative that clinicians referring patients for diagnostic imaging be informed of any abnormal findings in a timely and appropriate manner. It was found that the operational practice, supported by hospital policy, was to immediately verbally communicate any abnormal findings to the referring clinician. However, at the time of the investigation it was found that whilst a pilot proof of concept for critical alerts had been tested, and funding sought by the Hospital from the HSE, there was no electronic critical alert system in place to ensure a seamless reporting process at the Hospital. In addition, it was reported at interview that there was no formal system for GPs to access consultant radiologists. In consideration of the potential for patient safety events to occur in the absence of such a formal system, it is of concern to the Authority that an electronic critical alert system is yet to be implemented at the Hospital.

In the imaging department the quality assurance arrangements were reported to be in line with the peer review audit guidelines of the Faculty of Radiologists as part of the Royal College of Surgeons in Ireland with the imaging department holding a missed discrepancy meeting reviewing 50 scans monthly. However, it was also reported at interview that due to the volume of clinical activity and the lack of dedicated audit administrative support, audit activity was under-developed. Audit activity is essential in assuring the quality of the service being provided for the purpose of ensuring timely and informed decision-making for safe patient care. Therefore, audit within the imaging department should be developed and supported to provide the necessary assurances within the department and to the Hospital's clinical governance structure.

8.5 Inpatient and day case services

Patients requiring planned admission, for example, as an inpatient for a surgical procedure or as a day case for a medical assessment, should be assured that they will receive their care within an appropriate time frame. Waiting times are important to patients because their condition may deteriorate while waiting and their personal life and employment may be adversely affected by waiting. Once a patient is placed on a waiting list, the patient should expect to be seen within a reasonable time.

In 2011, the national target waiting time for adult elective inpatient admissions was 100% of patients waiting less than 6 months⁽³⁹⁾. In June 2011, the national figure reported by the HSE for all hospitals for adult elective inpatients waiting less than 6 months was reported as 68.7% ⁽³⁹⁾.

In December 2010, 71% of adult elective inpatients at the Hospital were waiting less than 6 months. This figure was recorded as 69% in June 2011 which demonstrates a small increase in the numbers of patients waiting beyond six months for an inpatient appointment. However, this is in line with the HSE nationally reported figure in June 2011 of 68.7%. Table 18 illustrates adult elective inpatient waiting list status as at 31 December 2010 and at 30 June 2011.

Table 18: Adult elective inpatient waiting list status as at 31 December 2010 and 30 June 2011

Number of Adult elective inpatients awaiting admission, as at as at 31 December 2010 and at 30 June 2011	0-3 months	3-6 months	6-12 months	12-24 months	More than 24 months	Total
At 31 December 2010	309	185	174	28	5	701
At 30 June 2011	252	170	133	45	15	615

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

In June 2011, the Special Delivery Unit (SDU) introduced a national waiting list initiative with the aim that no patient would be on an inpatient waiting list longer than 12 months by the end of 2011.⁽¹⁴⁾ The SDU has publicly reported that in 2011 all hospitals, including AMNCH, were on target to achieve this. At the time of the investigation, the results of this initiative were not available.

The HSE National Service Plan for 2012⁽⁴⁰⁾ includes a revised waiting list initiative to target patients waiting on an inpatient waiting list longer than nine months, with performance against this target to be published monthly in the HSE supplementary reports. However, the Authority was unable to verify this nationally reported measure given that no individual hospital's waiting times had been published.

It is crucial that all hospitals in Ireland have the appropriate arrangements in place to ensure that:

- a prioritisation process for patients on waiting lists that incorporates the urgency of their clinical status is in place and monitored
- the accountable consultant periodically reviews the patient waiting list
- there are effective communication processes in place with the patient's General Practitioner for them to report any change in the patient's condition to the appropriate clinical team
- there are effective communication arrangements in place to periodically update the patient as to the waiting time.

In addition to waiting list initiatives, the practice of ring-fencing surgical beds at hospital level should be utilised to support the effective and timely provision of elective surgery, based on patient need.

8.6 Day case waiting times

The HSE National Service Plan 2011⁽⁴¹⁾ reports the national target waiting time for adult day case patients as 100% of patients waiting less than six months. As at December, 2010, the overall national figure for adult day-case patients waiting less six months was 87.5%.⁽⁴²⁾ Performance at the Hospital for patients waiting less than six months was 97%. Table 19 illustrates the adult day case waiting list status as at 31 December 2010 and at 30 June 2011.

Table 19: Adult day case waiting list status as at 31 December 2010 and at 30 June 2011

Adult day case waiting lists	0-3 months	3-6 months	6-12 months	12-24 months	More than 24 months	Total	Total waiting less than 6 months	Total waiting less than 3 months
At 31 Dec 2010	912	474	37	5	0	1,428	1,386 (97%)	912 (64%)
At 30 June 2011	760	514	119	3	0	1,396	1,274 (91%)	760 (54%)

Source data: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

As at June 2011, the overall national figure for adult day case patients waiting less than 6 months was 80.5%.⁽³⁹⁾ Performance at the Hospital for patients waiting less than six months was 91%. At both December 2010 and June 2011, performance at the Hospital had exceeded the national overall figures for adult day case patients waiting less than six months.

8.7 Average length of inpatient stay and bed management

The achievement and maintenance of effective bed utilisation in any hospital requires a system which can create an actively managed equilibrium between both scheduled and unscheduled patient demand and bed capacity and bed utilisation. Hospitals usually experience far more variation in patterns of patient discharge planning than in patterns of patient admission. One of the reasons for this is that hospitals manage processes such as ward rounds differently. In addition, patients are admitted seven days a week but typically the majority are discharged five days a week. This results in highly variable and unpredictable lengths of patient stay which, when not actively managed by both clinicians and managers, become a significant weakness in the patient admission and discharge process in times of high patient activity and has the potential to result in adverse patient outcomes.

The 2012 HSE National Service Plan⁽⁴⁰⁾ has a target for all hospitals to have an overall average length of stay (ALOS) for patients of 5.6 days. Historically at the Hospital, the bed management and patient discharge function has worked independently of each other. However, effective bed management, to include patient discharge planning, must be integrated and underpinned by robust multi-professional and multidisciplinary practices.

In June 2011, an overall average length of stay (ALOS) for patients of 5.9 days was recorded across all hospitals in Ireland.⁽³⁹⁾ However, it was reported by the Hospital that they were outside the average of 5.9 days, with an average length of patient stay of 6.86 days being reported in June 2011 with medical ALOS of 6.99 days and surgical ALOS reported at 6.6 days. These figures exclude patients with a greater than 30 days length of stay.

Table 20 shows an analysis of the average length of stay (ALOS) for the top 10 principal diagnoses for patients in AMNCH contrasted with the national ALOS.

Table 20: Length of stay for the top 10 principal diagnoses for all inpatients at AMNCH and at National level

Principal Diagnosis by AMNCH and overall national data by volume, by length of stay (LOS)	2010			
	AMNCH		National data	
	Number of discharges	Average LOS	Number of discharges	Average LOS
Chest pain (unspecified)	816	2.3	8510	2.4
Pneumonia (unspecified)	379	15.3	6881	11.9
Ureteric calculus	280	2.9	1187	2.8
Syncope and collapse	248	11.1	6159	6.0
Chronic obstructive pulmonary disease with acute lower respiratory infection	229	11.9	5433	10.7
Atherosclerotic heart disease of native coronary artery	218	5.0	3861	5.0
Urinary tract infection (site not specified)	201	17.3	5831	10.1
Fracture of lower end of radius (unspecified)	201	3.3	1604	2.5
Chronic obstructive pulmonary disease with acute exacerbation (unspecified)	194	7.8	4811	8.5
Headache	188	5.0	3882	2.6

Source data: ESRI, HIPE

In recognition of this problem the Hospital had, as part of the Quality improvement Plan, implemented several operational strategies which included bed management practices, expanded pre-admission assessment services, ward rounds scheduling and day of admission processes. In addition, it was found that the development of a respiratory pathway for patients with Chronic Obstructive Pulmonary Airways Disease between the Hospital and Peamount Hospital had saved approximately 10,000 hospital days in the Hospital. It was also reported at interview that the ALOS had been reduced in elective orthopaedics and urology services, this was in part due to the ring fencing of surgical beds to these specialities.

Longer term plans included the reduction of the average patient length of stay in the Hospital by 2.7 days and the development of an admission avoidance strategy through, for example, diverting patients to contracted diagnostic testing, chest pain clinics and COPD outreach programmes, and the planned implementation of the National Clinical Care Programmes.

At the Hospital, the greatest deviation from the national ALOS occurred for patients with a fracture of the neck of femur (broken hip) where the ALOS is longer than the national ALOS by 7.3 days. This was followed by patients with a urinary tract infection and patients with chronic kidney disease, stage 5, at 7.2 and 7.1 days longer than the national ALOS for these principal diagnoses. Patients being admitted with urinary tract infections accounted for a total of 201 discharges from the Hospital in 2010 and ranks seventh on the list of top 10 principal diagnoses for the total inpatient discharges in 2010. Table 21 below illustrates, those principal diagnoses for which the Average Length of Stay at the Hospital deviates greatest from the National Average Length of Stay for the same diagnoses.

Table 21: Top 5 Principal Diagnoses (based on difference between National and the Hospital Average Length of Stay (ALOS) (Minimum Number of cases =50)

Principal Diagnosis	AMNCH Number of discharges	AMNCH ALOS	National Number of discharges	National ALOS	Difference in ALOS
Fracture of neck of femur(part unspecified)	76	26.4	1353	19.1	-7.3
Urinary tract infection (site not specified)	201	17.3	5831	10.1	-7.2
Chronic kidney disease, stage 5	77	17	621	9.9	-7.1
Other and unspecified convulsions	53	11.1	2231	5.1	-6
Crohn's disease (unspecified)	73	14.8	453	9.2	-5.6

Source data: ESRI, HIPE

Hospitals will have to actively manage and reduce the length of patient stay, safely, to free bed capacity within the Irish Health System. This will require proactive planning of the whole process of patient care as well as active discharge planning. At the time of the commencement of the investigation, the bed management and patient discharge functions at the Hospital had recently merged.

8.7.1 Day of Procedure Admission Rate for Elective Inpatients

Length of patient stay can be further reduced by having appropriate arrangements in place for patients to be admitted on the day of their procedure with a national target set by the HSE of 75%. The overall national figure for day of procedure admission rates in hospitals across Ireland for elective inpatients was 49% for October 2011.

Based on the HealthStat dashboard report for the Hospital in October 2011, the overall rate of procedures carried out on the same day of patient admission was at approximately 38%. The higher performing specialties were those of Gynaecology, Gastroenterology and Medicine with over 60% of procedures carried out on the day of patient admission. This was followed by Trauma and Orthopaedics (35%), Surgery (30%), Urology (28%) and Cardiology at (22%). Therefore, there is a significant opportunity for the Hospital to reduce their length of stay by ensuring the necessary arrangements for example pre-anaesthetic assessment services, patient admission lounges and revised working start and finishing times are put in place.

8.8 Actively managing patient discharge

8.8.1 Ward Rounds

One significant step in reducing patient length of stay safely is to ensure that structured early ward rounds by senior clinical decision makers are undertaken daily. It was reported at interview that, although clinical teams do attempt to conduct early ward rounds, patients under the same speciality could be allocated an inpatient bed on any ward, with ring-fenced beds at the time of the investigation only assigned to a small number of specialities including orthopaedics, oncology and urology.

This means that clinical teams have to go to several wards to review their patients which, as reported, could cause significant delays. Notwithstanding this, it was also reported at interview, and seen during the observation, that there was a disparity in the frequency of ward rounds and that proactive patient discharge planning was not consistently supported by all clinical disciplines.

The Authority recognises that this is a challenge across all hospitals in the Irish Health Service. However, this must be actively managed by clinical and non-clinical managers in order to enhance timely patient access to senior

clinical decision making. This is particularly important in a resource constrained environment and should become part of the overall responsibilities of consultant staff in the undertaking of their role and in the supervision of their clinical team.

8.8.2 Estimated Expected Date of Discharge

National best practice identifies that compliance by all clinical staff in estimating the date of patient discharge on admission, and monitoring it thereafter, focuses a timely coordinated approach to clinical care. In addition, this assists the bed management team to proactively manage and estimate bed availability, assists in reducing the length of a patient's stay and facilitates the patient and their family to plan for their discharge from hospital.⁽⁴³⁾

As part of the Hospital's Quality Improvement Plan (QIP) a number of initiatives had begun which included active patient discharge planning to include identifying an estimated date of discharge (EDD) at the time of the patient's admission. It was reported at interview, and in the documentary evidence submitted by the Hospital, that internal audits demonstrated at the time of the investigation that 64% of all patients had an estimated date of discharge recorded on admission.

8.8.3 Timely Patient Discharge

To manage timely patient discharge arrangements the discharge documentation, follow-up appointments and transport arrangements should be in place to ensure that once a patient is discharged they can leave the hospital on time.

The Hospital had a patient discharge lounge which was used as a waiting area for patients to be collected. It was found that this was working well. In addition, the bed management department had structured early morning patient discharge ward rounds. This meant that members of the Bed Management Department went to the clinical areas each morning to ensure that all the necessary arrangements were in place to ensure patients planned for discharge were appropriately prepared for their timely discharge from the Hospital.

It was reported at interview that clinically experienced nursing staff would know when a patient could be discharged but would have to wait for the medical or surgical team to make the decision. At the time of investigation there was no nurse-led discharge taking place at the Hospital. The practice of nurse-led discharge could potentially accelerate the patient discharge process, assist in freeing-up of inpatient beds and reduce the wait times for emergency patients awaiting transfer from the ED to an inpatient bed. The Authority recognises that this is not specific to the Hospital and nationally nurse-led patient discharge protocols should be developed and implemented.

To ensure effective bed management, it is imperative that discharged patients vacate their inpatient bed as early as possible when safe to do so. National guidelines⁽⁴³⁾ recommend that discharged patients leave the hospital before 11.00 hours. Aligned to national best practice guidelines on discharge planning, as part

of the QIP, a 'home before 11am' initiative had been implemented. However, as this was a recent development at the time of reporting it was not possible for the Authority to assess how well this was working.

8.8.4 Long-term Care / Community Services

Some patients who are admitted acutely to hospital, due to their clinical and/or social circumstances, may not be able to be readily discharged home and may, for example, require an intermediate support arrangement in another facility in order to rehabilitate them back to their home. It may be that they require a home support package, community care or residential long-term care. Consequently, it is important that there are appropriate arrangements within the hospital to support the patient and their families. Therefore, depending on the assessed needs, and taking into account the wishes of the patient and their family members, when a dependent patient is discharged from an acute hospital, there should be access to the appropriate community facilities such as:

- home care packages
- short term/intermediate care in a community setting in advance of discharge to home with or without a home care package
- short or long-term residential care services for patients to be directly admitted to from the acute care setting.

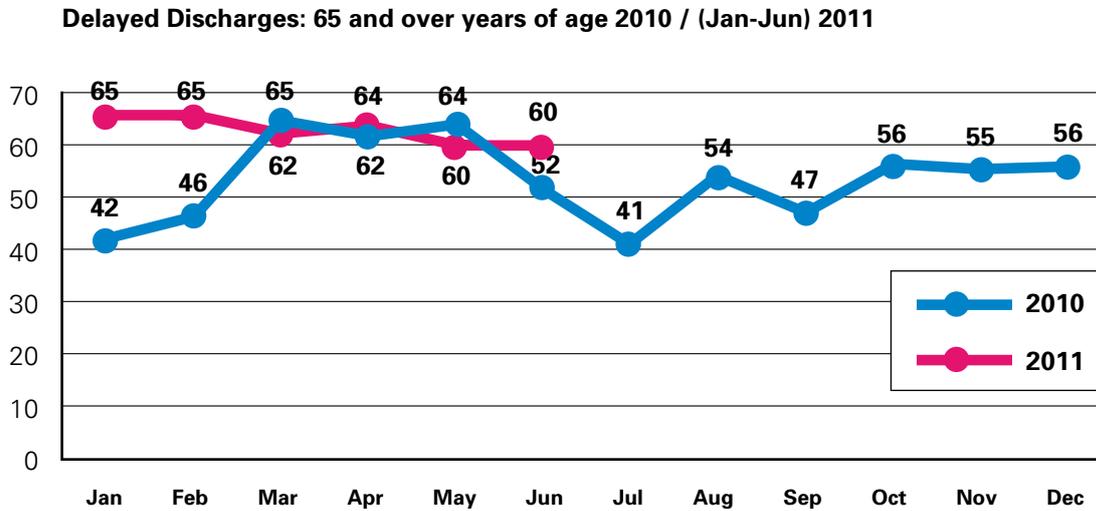
All of these supports require ongoing and effective relationships between the hospital and these key partners.

8.8.5 Delayed Patient Discharges

A Delayed Patient Discharge is defined as patients who have completed the acute phase of their care and are medically fit for discharge into a non-acute setting⁽³³⁾. Patients with a delayed discharge from an acute hospital are categorised as patients aged 65 years and over or patients aged under 65 years.

The Hospital, over the period of January to June 2011, reported a monthly average of 63 delayed discharges for patients aged 65 years and over as illustrated in Figure 6.

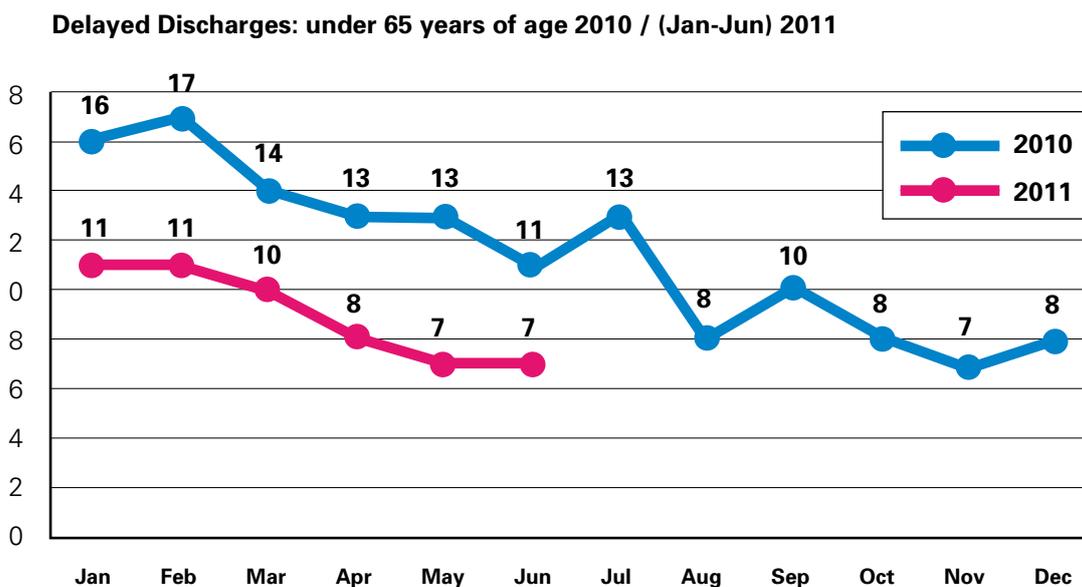
Figure 6: Number of delayed discharges for patients aged 65 years and over in 2010 and from January to June 2011



Source data: Adelaide and Meath Hospital, incorporating the National Children's Hospital

Over the period of January to June 2011, a monthly average of 9 delayed patient discharges for patients aged under 65 was reported, as outlined in Figure 7 below.

Figure 7: Number of delayed discharges for patients under 65 in 2010 and from January to June 2011



Source data: Adelaide and Meath Hospital, incorporating the National Children's Hospital

The Authority found that the historic lack of an integrated approach to patient admission and discharge planning at the Hospital had contributed to challenges at the Hospital with timely discharge of patients. In 2010 and 2011, the HSE had worked with the Hospital to help reduce the number of patient delayed discharges. For example, by providing training on patient discharge planning and the allocation of a staff member from the Nursing homes unit of the HSE to the Hospital to assist with patients with complex needs.

However, despite these initiatives, ongoing external factors which contributed to delayed patient discharge were reported by hospital staff which included, patients awaiting HSE funding approval for a nursing home bed, nursing home bed availability for highly dependent patients and a shortage of mental health follow-up services available in the community.

The HSE monitors delayed patient discharges reported by acute hospitals as part of the HealthStat performance information and improvement system on a monthly basis. Each hospital conducts a weekly census of the number of delayed discharges. As at 23 January 2012, the Hospital recorded a total of 61 patients categorised as a delayed discharge, 60% of those patients had a delayed discharge of more than 4 weeks⁽⁴⁴⁾. Table 22 illustrates the breakdown of delayed discharges by defined time bands as at 23 January 2012.

Table 22 Number/percentage of delayed discharges at the Hospital by time band as at 23 January 2011

Delayed Discharges by Time Band	0-2 weeks	2-4 weeks	4-26 weeks	More than 26 weeks
Number	15	9	33	4
Percentage	25%	15%	54%	6%

Source data: HSE

As a proportion of the overall population it is projected that the proportion of people over 75 years of age is set to increase from 5 to 10% by 2031 to between 20 to 25% of the population by 2041. It is expected that those over 85 years of age will increase by 105% by 2031⁽⁴⁵⁾. In this context health is a key determinant of the quality of life and wellbeing for older people. Ageing tends to be associated with complex and often inter-related health problems. Consequently, health care for older persons, who often have complex health and social care needs, requires an integrated approach moving the balance of care away from the acute sector to the primary and community care sectors when appropriate and timely to do so.

At the time of the investigation, the National Clinical Care Programmes had ongoing work in the management of chronic illness. However, care in hospital will continue to be an important component of these new programmes. As outlined there are major implications for the acute health service when patients, clinically

discharged, have to stay longer than necessary in hospital. Importantly, studies show that there are also major negative implications for these patients. For example, feelings of disempowerment, low mood, increased dependency and poor health and higher risk of acquiring healthcare associated infections⁽⁴⁵⁾.

Therefore, it is imperative given that older people are the largest consumer of healthcare services in Ireland, that the system at hospital, community and residential level are appropriately organised to respond to their needs.

These arrangements should include at a hospital level:

- timely access to specialist care of the elderly services
- robust timely communication and cooperation between hospitals and community services, public health and general practice
- occupational therapy assessment of individual patient needs and of their home
- a multidisciplinary and multi-professional approach to care.

To assist in preventing avoidable hospital admission and facilitation of early discharge from hospital, the following types of interventions should be considered which include:

- timely access to multidisciplinary elderly care and rehabilitation services
- early multi-professional and multidisciplinary assessment of a person's needs
- intermediate /short-term step down support and rehabilitation and respite facilities timely access to community intervention teams
- home help packages.

To assist in the timely patient discharge to an appropriate residential service the Hospital and the HSE must ensure that robust arrangements are in place to support these patients, provide adequate facilities and reduce the time the patient has to inappropriately spend in an acute hospital.

At the time of the investigation, the Hospital had acute gerontology services, and a number of good practice interventions in place to support early patient discharge home. These included the Emergency Department secondary triage process and a community intravenous service which facilitated patients on intravenous therapy having hospital staff going to the patient's home to administer their medication. It was found that this initiative was effective with a 3.2% patient readmission rate and a high patient satisfaction rate.

Nationally, in 2012, the National Service Plan target for all hospitals is to reduce the number of delayed patient discharges by 10% and the number of bed days lost due to delayed discharge by 10%⁽⁴⁰⁾. As at 23 January 2012, a total of 763 patients categorised as a delayed discharge were recorded nationally⁽⁴⁴⁾. Table 23 illustrates the breakdown of delayed discharges by the main reasons for the delay and by defined time bands as at 23 January 2012.

Table 23: Delayed discharges by the main reasons for the delay, by time band as at 23 January 2012

Main Reasons for Delay	0-2 weeks	2-4 weeks	4-26 weeks	More than 26 weeks	Number of Delayed Discharges
NHSS ⁹ – HSE determinations in Process	67	46	88	14	263
NHSS application not yet submitted	64	24	43	2	162
Patient awaiting bed due to particular care requirements	13	17	37	10	87
Awaiting external rehabilitation	45	12	7	0	72

Source data: HSE

It is unacceptable that patients who have completed their acute care episode remain for extended periods in acute hospitals in Ireland, whilst the Authority recognises that efforts are being made to address this planning deficit, substantial further work is required to address this to a more satisfactory level.

At the time of the investigation, the National Care of the Elderly Programme had not been published. However, a review of the Programme, submitted to the Authority by the HSE, showed a model of care to meet the needs of the older person which involved a multi-professional approach. The model of care proposes for example, on-site in the hospital and off site rehabilitation wards with rapid access to ambulatory or day hospital services, with services located at convenient sites in the community. The 2012 HSE Service Plan has set a target completion date to roll out a comprehensive elderly care service model in suitable sites. However, at the time of the investigation the National Care of the Elderly Programme was not identified in the documentation received by the Authority as being part of the suite of Clinical Care Programmes being introduced at the Hospital.

8.9 Conclusions

At the time of the investigation, work was ongoing at the Hospital to improve outpatient services whilst also implementing the recommendations of the Hayes Report.

However, further to the findings of the investigation, the Authority concluded that extended waiting times for both inpatient and outpatient diagnostic imaging at the Hospital, as well as diagnostic reporting turnaround times, requires further review and improvement. This includes the requirement to implement a process for the identification and prioritisation of diagnostic testing based on patient need, in addition to the implementation of an electronic critical alert system to ensure timely information regarding a patient's diagnosis.

At the time of the investigation, the Hospital was outside the national average of 5.9 days, with an average length of patient stay of 6.86 days being reported in June 2011. One significant step in reducing patient-length-of-stay safely is to ensure that structured ward rounds by senior clinical decision makers are undertaken daily. At the time of the investigation there was disparity in the frequency of ward rounds and proactive patient discharge planning was not consistently supported by all clinical disciplines. In recognition of the problem, the Hospital had begun to implement operational strategies in relation to bed management practices, active discharge planning practices, ward rounds and day-of-admission processes in order to improve performance against the HSE national target for the Average Length of Stay for admitted patients. However, the Authority found that a greater focus must be placed on ensuring that the appropriate local, regional and national arrangements are in place to ensure that appropriate community, intermediate, short-term and long-term residential facilities are available to patients and their families.

From January to August 2011, a total of 1158 adult elective inpatients and 809 adult day case patients who had been scheduled for admission had been cancelled by the Hospital or the patients Consultant. This is not acceptable. It is important that elective surgery and scheduled diagnostic and therapeutic access for patients is managed, protected and waiting times informed, based on patient need. If it is not, patients may be at risk and may perceive that they have no other option but to seek alternative means of accessing healthcare, for example through the emergency department. It is imperative that hospitals, the HSE and the Special Delivery Unit implement and monitor efficiency strategies to actively maintain timely patient access to both scheduled and unscheduled care.

Timely access to diagnostics is a requirement of all safe, efficient and effective health services. In the context of providing timely access for patients, and managing resources in the most efficient way, the Authority considers that access to certain types of high demand, low capacity diagnostic imaging should be considered from a regional and national perspective. This arrangement should be developed, managed and coordinated as a shared resource across all hospitals and primary care – particularly for patients waiting for long periods.

Recommendations – Scheduled Care

Managing the Patient Admission and Discharge Pathway

1. The Hospital must engage fully and effectively with the range of stakeholders, including general practitioners, in order to ensure the most effective referral process for patients. This should be monitored and evaluated on an ongoing basis.
2. The HSE nationally and the Special Delivery Unit must ensure that there is a nationally integrated programme-managed approach to the implementation of the Clinical Care Programmes and patient admission and discharge strategies across the country which is effectively led, governed, managed and monitored at national level. This process should provide active support to local service providers in order to ensure that the local implementation of each National Clinical Programme is managed as a single integrated and seamless improvement plan within a hospital and community and not as separate, fragmented and isolated initiatives that have the potential to result in competing priorities and resources.
3. All hospitals should have the appropriate implementation and monitoring arrangements in place to ensure that early morning ward rounds are undertaken by senior clinical decision makers and that these form part of the explicit responsibilities of each consultant. Wherever possible, to facilitate multidisciplinary interactions and timely ward rounds, patients should be accommodated in centralised areas aligned to their admitting speciality.
4. All hospitals in Ireland should ensure that active patient discharge planning management is in place to include each patient having an individual discharge care plan with an estimated date of discharge from hospital.
5. The Health Service Executive and the Department of Health must as a priority review the current arrangements to provide patient access to multidisciplinary rehabilitation, community support and intermediate- and long-term care for patients requiring residential services. An integrated approach should be implemented, involving all health and social care professionals, with identified critical decision making at key points and key performance indicators to ensure a timely and seamless transition for the admission to and discharge from the acute service.
6. All hospitals should consider, where appropriate, safe mechanisms for implementing nurse-led patient discharge processes with the appropriate supporting clinical governance arrangements.

Clinical Governance

7. All hospitals should have effective arrangements in place to ensure that all patient waiting lists are periodically reviewed by a senior clinical decision maker to ensure that the clinical priority and urgency for each patient is managed and subject to regular review. Arrangements should include two-way communication with the patient and their general practitioner.
8. Voice recognition and clinical alert software with a formalised process for critical alerts to GPs for abnormal patient imaging results must be put in place in all hospitals and monitored and evaluated on an ongoing basis.

Managing Performance and Information

9. The Hospital should ensure that all initiatives taken to improve the efficiency and effectiveness of the Outpatient Department's 'Did Not Attend' rate should be monitored to measure their impact, and to identify any areas where additional gains may be achieved.
10. The Hospital should formally review and validate the patient waiting list for diagnostic imaging on an ongoing basis and establish a prioritisation process with appropriate monitoring mechanisms.
11. An analysis of activity, demand and utilisation should be undertaken in each hospital providing diagnostic services with a view to extending opening hours to better meet the needs of patients.
12. Access to high demand, low capacity diagnostic imaging (for example, CT and MRI scans) should be reviewed at a regional and national level and the HSE nationally should develop, manage and coordinate access and waiting times for this type of imaging as a shared resource across all hospitals and primary care – particularly where there are long waiting times for patients.
13. Benchmarking and publication of outpatient department (OPD) appointment wait times across all hospitals at a national, regional, local and consultant level should be put in place.

Part 3

Leadership, Governance and Management

Introduction to Part 3

The sustainable delivery of safe, effective and reliable person-centred care and support depends on service providers having competent capability and capacity in the areas of leadership, governance and management.

Effective leadership is essential for the delivery of high quality and safe care and for promoting a culture of learning and continuous improvement. It is a key component of stewardship and is an essential element of good governance.

Good governance in healthcare is an integration of both effective corporate and clinical governance. This includes the systems, processes and behaviours by which an organisation or service is led, directed, managed and controlled in order to achieve its objectives in the provision of high quality and safe services for service users⁽⁵⁾.

Corporate governance is the system by which services direct and control their functions in order to achieve organisational objectives, manage their business processes, meet required standards of accountability, integrity and propriety and relate to external stakeholders. Strategic planning is the process of generating and reviewing alternative longer term directions for an organisation that leads towards the achievement of its purpose and should ensure that the delivery of services is only within the scope of what it can do safely, effectively and sustainably.

Clinical governance is the system through which service providers are accountable for continuously improving the quality of clinical care and safeguarding high standards of care for patients by creating an environment in which excellence in clinical care will flourish. This includes engaging and involving patients in their care and in the planning of services and mechanisms for monitoring clinical quality and safety.

These two elements of governance should work together in a complementary way to ensure that the sole focus of a healthcare organisation is on the patients that it serves⁽⁵⁾.

A well led, governed and managed service should be clear about what it does and how it does it and be accountable to its stakeholders. It is unambiguous about who has overall executive accountability for the quality and safety of the services delivered to patients. Formalised governance arrangements ensure that there are clear lines of accountability at individual, team and service levels so that healthcare professionals, managers and everyone working in the service are aware of their responsibilities and accountabilities. The accountability arrangements in a service

should be reviewed regularly to ensure that they are fit for purpose, robust and effective. These arrangements should also acknowledge, and make provisions for, the relationships and inter-dependencies between service providers and other key stakeholders that are necessary to deliver high quality, safe and reliable care and support.

Governance and management arrangements in healthcare organisations and services must ensure that the primary focus of the service is on the provision of high quality care and safe outcomes for patients. These arrangements should include the regular review of information relating to the quality and safety of care and outcomes for service users in order to ensure that these outcomes are being delivered ⁽⁵⁾

9 Board Governance

9.1 Introduction

The focus of governance and the roles, responsibilities and accountabilities of hospital boards have evolved. In 2012, the focus of a hospital board must be setting the strategic direction, establishing effective corporate and clinical governance arrangements, assuring itself by holding the executives to account, that the hospital is being well run and providing good quality and safe care as part of a national health system within the allocated resources.⁽¹³⁾ Its function is not to manage the hospital. The board's task is to direct the hospital. This activity includes four main elements:

- strategic planning
- policy making
- supervision and challenge of executive management
- accountability to stakeholders.

The governing boards of service providers should set the tone from the top and play a pivotal role in leading and building a culture that puts quality and safety at the centre of the delivery of care. The board should hold the chief executive and the executive management team, who are responsible for managing the hospital, to account through a clearly defined scheme of delegation of accountabilities. Boards need to be confident by seeking and receiving assurances from the executives, through a process of constructive challenge, that the arrangements, systems, processes and people that they have in place are operating in a way that it is safe, effective, managing risks for service users and achieving the articulated objectives of the hospital within the available resources.

All service providers in receipt of funding from the HSE are required to have internal codes of governance in place, including an adequate system of internal controls, to ensure compliance with laws and regulations. The service provider is required to use the *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ as a guide for drawing up such codes of governance. In addition, these service providers must have in place governance arrangements with defined management processes, organisational roles, responsibilities and reporting relationships, which support the provision of safe and high quality services. AMNCH is such an organisation in receipt of funding from the HSE for the provision of services under section 38 of the Health Act 2004.^(47,48,49)

It is important to emphasise that an effective board is collectively responsible for the success of an organisation. Such boards recognise that all board members who participate, or are entitled to participate, in decision making are equally responsible for the consequences of the board's decisions and actions and should support and abide by the board's decisions even if they did not participate in the decision or did not agree with the decision.

This section of the Report will outline the Authority's findings in relation to the governance of the Hospital in respect of the third Term of Reference. It focuses on the period 1 January 2010 to 28 July 2011.

The Authority used key Lines of Enquiry, as outlined in Subsection 2.4 of the Report, to review the effectiveness of the governance of the Hospital. The investigation focused on the time period from 2010 to 2011 which covered the term of the then current Hospital Board and the Transitional Board of Management. The Lines of Enquiry were developed to guide the investigation approach in order to fulfil the Terms of Reference. These assessed how well the Board and Executive Management ensured that they and the Hospital staff:

- were clear about what services they provided, how they delivered them and the accountability arrangements to their stakeholders
- were unambiguous about who had overall executive accountability for the quality and safety of the services delivered
- had formalised integrated managerial and clinical governance arrangements with clear lines of accountability at individual, team and service levels
- ensured that the leaders at all levels in the Hospital built and supported a culture that inspired individuals and teams to strive and work together to achieve a common vision
- ensured that the workforce were aware of their responsibilities and accountabilities
- ensured that robust arrangements were in place for the planning, controlling and organising of the service to achieve the best outcomes for patients in the short, medium, and long term
- had effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering
- had effective management arrangements to facilitate the delivery of high quality, safe, reliable care and support by allocating the necessary resources through informed decisions and actions
- had robust arrangements in place at a local level to ensure the alignment of local, regional and national accountability for planning and delivering services
- had arrangements in place to plan and manage service change and transition effectively and safely.

9.2 Governance structure

The boards of three hospitals; the Adelaide Hospital, the Meath Hospital and the National Children's Hospital, came to an agreement that the activities of each of these hospitals should be combined and carried out by a single organisation on a site at Tallaght. However, these boards requested that 'the letters patent of the 27th day of November, 1920' granting incorporation to the Adelaide Hospital, Dublin as amended by the Adelaide Hospital (Charter amendment) Order, 1980 be amended to enable this agreement. Consequently, the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital entity was established on 1 August 1996 by order of the Minister for Health in accordance with section 76 of the Health Act 1970⁽¹²⁾. This Order, together with the Charter which it amended, is subsequently referred to as the Charter.⁽¹²⁾

9.3 The Hospital Board structure and composition

Best practice for the composition of boards is to independently appoint board members with the collective range of knowledge, skills, competencies and experience necessary to effectively govern the organisation and who are free from overt conflicts of interest. The size and composition of a board should reflect the scale and complexity of the organisation's activities without becoming unwieldy.⁽¹³⁾

The Hospital Board appointments were governed by the Charter. The Charter provided that the Board consist of 23 members and be comprised as follows:

- 6 members appointed by the Adelaide Hospital Society
- 6 members appointed by the Meath Hospital Foundation
- 3 members appointed by the National Children's Hospital
- 6 members appointed by the Minister for Health from persons nominated by the President of the Hospital (Church of Ireland Archbishop of Dublin)
- 2 members appointed by the Minister for Health, 1 nominated by the HSE and the other nominated by the Board of Trinity College, Dublin.⁽¹²⁾

In line with the Charter, before nominating the six designated members for appointment, the President of the Board as the Church of Ireland Archbishop of Dublin, was required to consult with other major Protestant Churches in the State and have consideration that the nominated persons reflected the position of the Hospital as a focus for participation by Protestant denominations in the health service.⁽¹²⁾ The Charter also provided for proposals by the Paediatric Medical Advisory Committee, a committee of the Paediatric Committee of the Hospital, also known as the National Children's Hospital (NCH), of one or more persons for appointment by the NCH as members of the Board. The Medical Board of the Hospital was also required to propose one or more persons for appointment by the Adelaide Hospital Society and the Meath Hospital as members of the Board. The Charter states that at least one of those proposed for appointment by each of

the founding organisations, the Adelaide Hospital Society, the Meath Hospital and the NCH, must hold a consultant medical post in the Hospital.⁽¹²⁾ Board members voluntarily gave their time to the Board and were not in receipt of any fees.

At the time of the commencement of the investigation, and in line with the Charter, the Board consisted of 23 members. The term of office for Board Members was for three years and individuals could be reappointed.⁽¹²⁾ The HSE did not nominate a member to the 2008 to 2011 Board. Over half of the Board Members were selected by one of the founding hospitals' organisations – the Adelaide Hospital Society, the Meath Hospital Foundation and the National Children's Hospital – as their appointees.

The Board included a number of the Hospital's consultant and clinical staff. Seven of the Board members were medical doctors who were employed by the Hospital. The Charter does not identify the role of the Chief Executive. The Chief Executive was in attendance at the Board meetings rather than being a member of the Board. The Charter also allowed for the Chairperson and Secretary of the Medical Board to attend in an ex-officio capacity and participate in all meetings of the Hospital Board.⁽¹²⁾

This appointment of Hospital staff to the Board, when the Chief Executive is only 'in attendance', is not reflective of good governance. This practice has the potential to undermine the role and the accountability of the Chief Executive as well as giving rise to potential conflicts of interests in relation to operational and financial issues, such as private practice arrangements and the oversight of safety and quality matters.⁽¹³⁾

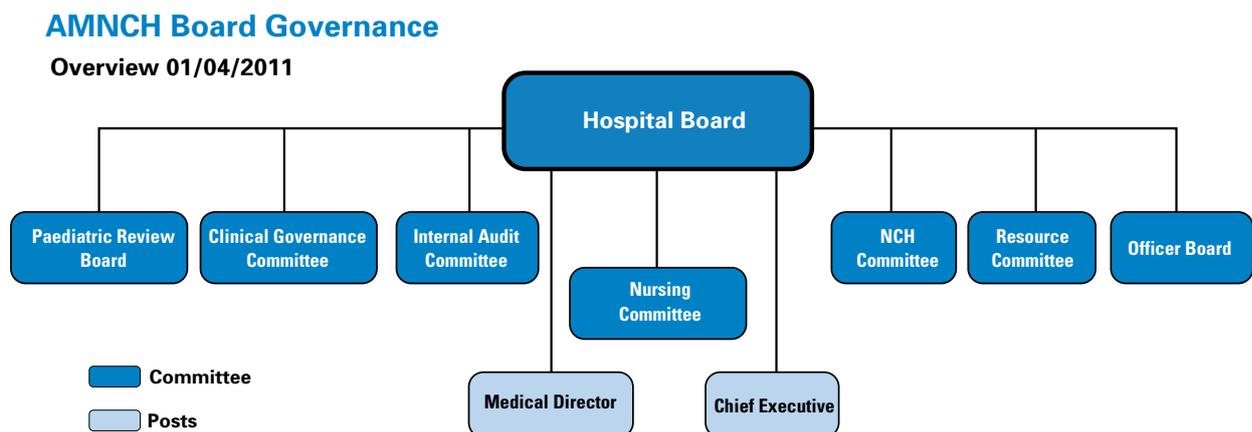
In addition, as Board members could potentially hold a number of posts within the Hospital at any one time, it was reported to the Investigation Team that there could be a lack of clarity in relation to the actual role and function being represented by these members at Board meetings. For example, during a period between January and July 2010, the Professor of Surgery, who also had a role as the Hospital's Medical Director and was a member of the Board, was appointed as the Chief Executive designate. During this period it was not always clear to some Board members which role was being discharged by the post holder at any given time. In addition, in 2010, the Chief Executive designate resigned from this post and remained as a member of the Board. This is not in line with good corporate governance.

During the period of the investigation, the term of office of the 2008 to 2011 Hospital Board ended in July 2011 when a new Board was appointed. However, at the instruction of the Minister for Health, this Board was replaced by an Interim Board in December 2011. In addition, a Transition Board was established by the Hospital in September 2010 to support the 2008-2011 Hospital Board. Its term ended in July 2011.

9.4 Board structures

A diagram, dated 1 April 2011, depicting the organisational structure (Figure 8) was provided by the Hospital to the Authority to describe the Board governance arrangements. However, the Authority found that these governance arrangements, as described in the diagram, were not consistent with the Hospital's corporate and clinical governance arrangements as described at interviews and in other documents. The diagram identified two roles that reported directly to the Board. However, this did not match the corporate and clinical governance organisational structure also submitted. In addition, the Transitional Board, a Committee of the Board of Management, was in place from September 2010 until July 2011. In the diagram, this Committee was not identified as a committee of the Board. In addition, these arrangements were not publicly available or clearly understood by all of those interviewed as part of the investigation.

Figure 8: The Hospital Board Governance



Source: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

The Authority reviewed the results of the governance survey as part of the *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*,⁽³⁾ commissioned by the Board in 2009, in relation to the Board structure and composition which found that:

- 75% of Board Members agreed that the size of the Board inhibited decision making
- 50% of Board Members did not agree that the composition of the Board was correct.

9.5 The Board's role and functions

The Charter⁽¹²⁾ provided that all the powers of the Hospital are vested in and exercisable by the Hospital Board. It provided, among other things, that there shall be a Board of Management of the Hospital and that the general function of the Board shall be to manage the activities of the Hospital and the services provided by it as a public voluntary teaching hospital. These functions described by the Charter are not in line with the principles of modern corporate governance.

The Board of the Hospital had, and has, collective responsibility for its acts and omissions. In any board, all board members who participate, or who are entitled to participate, in decision making are equally responsible for the consequences of the board's decisions and actions even if they did not participate in the decision.⁽⁵⁰⁾

However, it is fair to point out that individual Board Members may not personally have been associated with certain acts or omissions referred to in this report, whether because of their dissent in relation to particular matters, simple non-involvement (whether generally, or because, for example, they were not on the Board at the time concerned), or otherwise. The same can be said for members of various Board Committees.

There were no role descriptions or objectives for Board Members in place. In 1997, the Board developed standing orders. These standing orders included the duties of the Chairperson, the Vice-Chairperson and the Honorary Treasurer, schedule of meetings, arrangements for voting, standing orders for Board committees and details of Board policies, for example, confidentiality and conflict of interest. Whilst the document submitted to the Authority also referenced the appointment of medical staff to the Board, the document suggested that this section was "to be completed later". The Authority found at the time of the commencement of the investigation that these standing orders had not been reviewed or evaluated since 1997.

In 2005, a Corporate Governance Manual was developed by the Board which evaluated the corporate governance arrangements at the Hospital against best practice. It proposed the duties of Board members and Board officers, the role of sub-committees and the role of the Hospital Chief Executive in the management of the Hospital on behalf of the Board of Management. The stated functions of the Board included a responsibility to develop and review on a regular basis the mission, vision, objectives, functioning and strategic plan of the Board; to establish, implement and evaluate a quality management system for the regular assessment and review of patient care, and manage the property and finances of the Hospital.

In 2009, concerns about the existing governance arrangements were raised by some members of the Board. In response, an external *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ was commissioned by the Board and undertaken by external consultants. The external consultants presented the results of this survey

to Board members. The Authority was provided with a copy of the PowerPoint slide presentation of the review which included the results of a survey of Board Member's views. The Authority requested but did not receive a copy of the full report that accompanied this PowerPoint presentation. The Authority reviewed the results of this survey. Examples of the survey findings included that:

- 38% of those surveyed agreed that the Charter set out the Board responsibilities clearly
- 87% of those surveyed did not agree that the Board operated effectively
- 88% of those surveyed agreed that there was scope for improving on Board and Management relations.

The Authority makes further reference to the results of this survey in the remainder of this Report. This survey also found that only 25% of Board Members agreed that the Hospital management was effective in implementing Board decisions. It was suggested to the Authority that this lack of confidence, combined with the number of senior executive managers in temporary positions, may have led to the Board's extensive engagement in operational matters. However, notwithstanding these issues, the Authority found that the Board and the Executive's roles and responsibilities were not sufficiently differentiated or elucidated. There was no role description for Board Members and no clarity of accountability for decision making recorded. The roles of the Chairperson and the Chief Executive were not clearly differentiated and the division of responsibility between them was not set out in writing and approved by the Board. In addition, the Authority found that there was a lack of clarity in relation to the role, function, accountability, responsibility and authority for individuals holding a number of different posts at the same time.

The primary focus for boards of hospitals must be on the business of overseeing the safe delivery of care to patients.^(51, 52) It is recognised that such a focus requires a multi-faceted approach including effective service planning, resource management and stakeholder engagement.

There were alternative views and information provided to the Authority in relation to the Board's understanding of its role in the oversight of the delivery of safe care to patients. On the one hand, some Board members stated that the Board understood its role, in terms of the Charter, as having ultimate accountability for the Hospital and the quality of the care delivered to patients. However, there were examples where others struggled with this concept. A number of Board Members stated that they received sufficient updates on risk matters whereas others reported that they did not receive sufficient assurances about patient safety.

The role of the Board in the management of operational activities, although in line with the Charter, was not in line with good corporate governance. Notwithstanding the Charter being unreflective of modern corporate governance, this fact should not have inhibited the principles of good governance in how the Board undertook

its business.⁽⁵³⁾ Attempts were made by the former Chairperson to change the composition and roles of the Board in recognition of its challenges. This resulted in the engagement of a third party for the provision of a review of the corporate governance arrangements at the Hospital in 2009, the recommendations of which were agreed for implementation by the Board in October 2009. However, at the time of the commencement of the investigation, the majority of these recommendations were not implemented. A separate initiative was undertaken with the establishment of a Transitional Board in 2010.

9.5.1 Delegation of Accountability

The Authority found that Board meetings were scheduled on a monthly basis and the Board met for approximately 3 hours. There was no formal schedule of matters reserved to the Board for decision. There was evidence of poorly defined functions of the Board with Board Members engaging in operational rather than strategic issues.

The Authority found that there was no formal scheme of clearly defined delegation of operational or financial accountability to the Chief Executive or Executive Management Team. All deeds, transfers, assignments, contracts and obligations on behalf of the Hospital had to be signed, with the approval of the Board, by two of the Board Officers and the Chief Executive.

The Authority found that responsibility for decision making was sometimes dependent on the personality of the post-holder rather than as a result of clarification of responsibility or clear delegation. Examples reported to the Authority included that, despite a national strategy and plan for cancer care and the Section 38 Service Agreement, the Hospital's Executive Management Team had indicated to the HSE that they were not authorised by the Board to release staff to provide cancer services at other hospitals. Subsequently, the Authority was informed that in September 2011 the newly appointed Chief Executive instructed that pancreatic cancer resectional surgery was to cease at the Hospital and that extensive discussions had been held in relation to the transfer of relevant consultant surgeons' clinical sessions.

The Standing Orders of the Board provided for the Chairman to convene a special meeting of the Board if required. However, the Standing Orders did not specify what arrangements were in place for decision making outside of Board meetings. This, it was said, could lead to delays in authorising decisions.

The Authority found that the Board did not comply with the *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ in relation to delegated authority levels.

9.6 Board style, efficiency and effectiveness

A board must hold the chief executive and the executive management team to account and assure itself, and all stakeholders, that the hospital is providing safe, high quality care to patients in an environment of dignity within the available resources and operating as part of a wider health system.

An effective board needs to be confident, by constructively challenging and seeking and receiving assurances from the executive, and clinical management team where appropriate, that the arrangements, systems, processes and people that are in place are operating in a way that is well led, safe, effective, managing key risks and achieving the articulated objectives within a culture of openness, learning and continuous improvement. These include the arrangements to manage board meetings, agenda and minutes; board records; the role of the officer committee of the board; the style of board meetings; board member induction, training and development; the management of conflicts of interests and board evaluation.

9.6.1 Board agenda and minutes

The Board's Standing Orders stated that the order of business for Board Meetings should include:

- open the meeting with a prayer
- approve the minutes of the last meeting
- consider the business on the agenda for the meeting
- consider any issues arising from the dispatch of business at the meeting or at earlier meetings
- consider any urgent matters arising or matters permitted by the Chairman to be raised by persons present
- consider regular reports from Committees of the Board.

The Authority found that the agenda for Board meetings did not consistently differentiate between items for information, items for action and items for strategic discussion. There were no records in the minutes of "Board only" items. The minutes show there was no prioritisation given to items deferred at previous meetings or rotation of agenda items to ensure time for all relevant matters. However, in mid 2011, there was evidence to suggest that the Board had commenced utilising an action tracking process to link the previous meeting actions to the next meeting.

There was no information made available to the Authority as to how, beyond recording their attendance at Board meetings, the attendance records of individual Board members was evaluated.

9.6.2 Records of Board agendas, meetings, papers and presentations

The Authority found that neither the Board nor the Hospital were able to provide the Authority with full and complete copies of Board records. In response to the Authority's request for these records, the Hospital provided, in boxes from a third party, versions of untitled, undated and incomplete Board minutes. Further amended, undated incomplete papers were also provided. Following a further request, the Authority was provided with bound copies of the Board packs relating to Hospital Board meetings. However, these packs did not include papers distributed at Board meetings, additional circulated papers or presentations.

A number of Board members interviewed recounted to the Authority that the information provided to Board members was often incomplete or provided in the form of a PowerPoint presentation with no supporting documents. Others reported that they were satisfied with the quality of presentations, and the availability of supplementary information if required

The Authority's findings correlate with the results of the Board survey, part of the *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ commissioned by the Board, which found that 75% of the Board agreed the Board pack was not comprehensive. However, this survey also found that only 25% of Board Members agreed that they read the Board pack.

The Standing Orders state that there be an Annual Meeting at which the Annual Report be approved. However, the Authority was advised that no such report was available for 2009 or 2010. This is not in line with the *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ or the requirements of the service arrangement with the HSE.

9.6.3 The Officer Committee of the Board

The 1997 Standing Orders of the Board identified the officers of the Board as the Chairperson, Vice-Chairperson, Honorary Secretary and Honorary Treasurer. There were no records or information made available to the Authority that suggested that the Officer Committee met with the Chief Executive prior to Board meetings to develop the Board meeting agenda, to make decisions on behalf of the full Board, or to ensure input from and communication with the Board Committee chairpersons. There was information provided of dates and agendas of meetings between the Chairperson and the Chief Executive. However, there was no record available of the decisions made at these meetings.

9.6.4 Board meetings

Those interviewed, who had attended Board meetings, stated that the start of Board meetings were characterised by lengthy reflective examination of previous minutes. Interviewees recounted that this sometimes took up to 45 minutes. The lack of

a structured approach that differentiated items for information, discussion or decision had the potential to facilitate time to be spent on less important matters.

It was stated by some attendees that there was a tendency at Board meetings for some Board Members to seek to micromanage certain issues, which could result in an overly detailed focus on the operation of the Hospital, rather than a more appropriate strategic focus. This, it was suggested by some Board Members, may have been exacerbated by the number of Board members who were also members of staff and may also have been due to the high turnover of the Senior Executive Team. This included the fact that there had been five members of staff acting or deputising in the role of Chief Executive since 2009.

The Board's Standing Orders state that every Board Member attending Board meetings, those 'in attendance' and every member of a Board committee shall respect the confidentiality of, and owes a duty of confidentiality to, the Board in respect of all matters arising, discussed or decided by the Board or concerning any of the activities of the Hospital generally and abide by the Board policy in relation to press and media.

The Authority found that the results of the 2009 governance survey, part of the *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ commissioned by the Board, found that the selected qualitative feedback of Board Members views suggested there was some distrust among Board Members and that not all attendees of the Board were confident that discussions of meetings were confidential or that agreed decisions would be implemented. In addition, this survey of Board Members found that 75% of Board Members did not agree that the Board was an effective decision making entity, and that none agreed that the Board operated efficiently.

9.6.5 Board Member induction and training

The *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ states that all directors should receive a formal induction on joining the Board and should regularly update and refresh their skills and knowledge.

The Authority received conflicting evidence as to the extent of induction, education and training programmes in place for Board Members. The Hospital was requested by the Authority to provide details of a Board Induction Programme. This was not provided by the Hospital.

9.6.6 Management of conflicts of interest

Board Members reported that there were arrangements in place for an annual disclosure of interest declaration in compliance with the Ethics in Public Office Acts 1995 2001. However, there was no formal register of interests kept in order for such declarations to be reviewed by the Chairperson.

The 1997 Standing Orders state that any Board Member was obliged to declare a conflict of interest in any matter to be decided by the Board and to abide by the Board's decision as to whether they should vote on such a matter. An effective process for Board Members to declare conflicts of interest whilst conducting Board business would allow the Chairperson and Honorary Board Secretary to consider for themselves if there were agenda items that might possibly present a conflict of interest for Board members. The Authority was advised that no documentation or process existed where conflicts of interests were declared by Board Members for the years 2010 to 2011. In addition, the minutes of Board meetings did not record that Board members declared a conflict of interest and absented themselves from parts of meetings where they were potentially compromised. However, it was subsequently reported that there were occasions when Board Members or attendees did, in practice, absent themselves where there may have been perceived conflicts of interest.

The Authority found that the Board did not fully comply with procedures outlined with the requirements under the Ethics in Public Office Act 1995 and the Standards in Public Office Act 2001 as outlined in the *Code of Practice for the Governance of State Bodies*.⁽⁴⁶⁾

9.7 Strategic planning

Effective boards, together with the executive officers, should have a shared view of a hospital's future direction and purpose and oversee the formulation and development of a corporate strategy.⁽¹³⁾ Strategy should be informed by national health policy and strategic direction, financial situation, resource availability and the hospital's capacity and capability.

The HSE, as will be discussed in Chapter 11, did not provide a clear strategic direction for the delivery of unscheduled and scheduled acute healthcare in Dublin. However, there were a number of national changes and options that could have been considered in any review of the strategic direction for the Hospital. These included the:

- Health Act 2004⁽⁴⁷⁾ and the changed role and standing⁽⁴⁷⁾ of public voluntary hospitals
- funding provided by the HSE for defined services under a service arrangement
- national cancer control programme and the decision to move cancer services from the Hospital
- chosen location of the National Paediatric Hospital
- proposals in relation to the population catchment area
- Trinity Health Ireland Alliance (a proposed strategic alliance between the Hospital, St James's Hospital and Trinity College Dublin)

- proposed relocation of maternity services
- HSE request for the Hospital to develop a plan with their role as a major trauma centre.

The Authority did not find or obtain any information to suggest that the Board had led the development of a single integrated corporate and clinical strategy that took account of the changing external environment. Many of those interviewed believed that there had been historic under-resourcing of the hospital. In addition, they expressed concerns that the Board and staff at the Hospital were concerned about the future role of the Hospital following the decisions in relation to the location of the Cancer Centres and the National Paediatric Hospital. In response to these decisions, a number of draft strategy proposals were developed and copies of these were provided to the Authority. In addressing patient quality and safety issues, the Hospital had developed a draft Quality and Patient Safety Strategy (2010 – 2014), underpinned by core principles which promoted continuous quality improvement and that services provided by the Hospital would be safe, effective and person centred. However, there was no evidence that any of these were finalised and implemented. The Authority requested the 2011 Corporate Strategy in July 2011 but was advised that no document was available because it was in consultation phase.

There was no information provided to the Authority as to how the Board used the HSE Section 38 Service Agreement, ^(48,49) in accordance with the Health Act 2004⁽⁴⁷⁾, as a framework to identify a schedule of funded and unfunded services and to plan services. In the absence of such a schedule, or a single integrated corporate and clinical direction, the Authority found that some clinicians had developed individual clinical strategies and lobbied to expand and enhance services on behalf of their specialties without reference to the Section 38 Service Agreement and without a specific allocation of funding from the HSE.

The Authority found that some services, for example the haematology services, had expanded due to the temporary closures of similar services in other hospitals and by collegiate agreements made between individual consultants without any reference to the Executive Management Team or the Board. This resulted in the Hospital providing additional services without the necessary resources. This may have led to pressures in the delivery of other funded services, for example, orthopaedic, general surgery, urology, medical and emergency services, which resulted in delays for patients.

There were other examples provided to the Authority of the expansion of some services which had occurred in the absence of adequate resources. These included the establishment of a young adult cardiac service and the expansion of the oncology service. The high costs associated with the provision of unplanned expanded haematology and oncology services, in the absence of HSE approval and funding, had the potential to affect the financial spend of the Hospital.

In addition, it was indicated at interviews that the founding organisations provided resources for projects and research. The Authority recognises the importance of philanthropic funding and that innovation and research are essential components of teaching hospitals and a dynamic health service system and importantly may benefit future patients. However, the impact of such research and projects must take into account the consequences, intended or otherwise, for the delivery of services and the potential risk to patients who currently access these services

The Authority did not find information to suggest that the Board, when deciding to approve the development of services outside the scope of the HSE Service Agreement⁽⁴⁸⁾, understood that in accordance with their Section 38 Service Agreement they were solely responsible for any obligations or liabilities incurred.

9.8 Information used to monitor the delivery of safe patient care

A board must have access to the appropriate information in order to fulfil its role in effectively governing the sustainable delivery of safe care to patients.

The Authority received conflicting evidence as to the quality and detail of the information that was available to allow the Board to assure itself that the Hospital was a safe place for patients. The Board minutes did not tend to reflect that patient safety, clinical quality or treatment were discussed as a matter of course or that patient safety or patient outcomes were firmly on the Board's agenda. However, some Board members interviewed stated that the quality and safety of patient care had always been a priority for the Board. There was no information in the Board papers in relation to reports on patient complaints, trends in clinical incidents, adverse events or claims or the prevention and control of healthcare associated infection.

The Authority reviewed the following information that was provided to the Board:

■ **HSE HealthStat reports⁽⁵⁴⁾**

The Board minutes suggested that these were not considered other than by way of a commentary in the Chief Executive's Report.

■ **Annual Nursing Report**

The Department of Nursing presented an Annual Nursing Report to the Board which reported how the nursing service delivered care supported by a robust quality assurance system which included quality metrics.

■ **Chief Executive's Report**

The Board received reports from the Chief Executive. It was reported that these, in the main, had been verbal updates or in a PowerPoint format. The acting Chief Executive, on taking up appointment in 2010, had initiated written

reports to the Board. These reports included a section on risks and outlined some matters of patient safety including updates on the implementation of the Hayes Report and issues in relation to Data Protection.

■ **Monthly Performance Report**

In August 2010, the acting Chief Executive introduced a comprehensive 'performance report' which was presented on a monthly basis to the Board. The aim of the report was to provide an update against adopted key performance indicators and an update on the progress of change projects under the auspices of the Performance and Planning Directorate. In October 2010, the report outlined that the Executive Management Team was proposing five major programmes of work which included:

- Safety and quality
- Modernisation and reform
- Partnership
- Human Resources
- Finance.

It was reported to the Authority that monthly performance reports relating to these programmes of work were presented to the Transitional Board (see section 9.9.7).

A draft suite of quality and safety key performance indicators (KPIs) were developed in May 2011. Due to the non appointment of a Director of Quality and Safety and the non-establishment of a Quality and Safety directorate at the Hospital, at the time of the commencement of investigation, the roll-out of these had not been progressed.

■ **Director of Nursing Report**

The Nursing Department developed a suite of nursing sensitive outcome measurements and proposed providing the Board with a bi-monthly report of the results of the Nursing Instrument for Quality Assurance (NIQA) audits. The aim of these audits was to support nurses in clinical practice to measure and define the quality of their care delivery in eight key areas of practice and to identify risks to patient outcomes and safety. A ninth patient experience indicator was also developed. A report was included with Board papers in March 2011 but did not include results of the patient experience indicator.

■ **Patient Experience Information**

In 2010, the Hospital took part in the national survey, *Measuring the Patient's Experience of Hospital Services*⁽¹¹⁾, undertaken by the Irish Society for Quality and Safety in Healthcare. The key findings of this survey were based on the experiences of 278 patients who had been inpatients at the Hospital, with 56% of the respondents stating they had been admitted via the ED. This

survey showed that 61% (n=117) of those respondents admitted via the ED waited more than 6 hours from the time they had been informed they would be admitted before being transferred to an inpatient ward. Of those, 43% (n=83) waited more than 12 hours before being transferred to an inpatient ward. There was no record of how the Board considered the results of this survey in light of other information about patients waiting in the ED or requested an executive response and action plan for improvement.

9.8.1 Risk information

The minutes of the March and June 2011 Board meetings record that the Medical Director advised the Board that there was no proactive risk reporting or completed risk register in place. In addition, the minutes stated that the Board was advised that there was confusion about the executive operational accountability for quality and safety. The minutes of the Board meeting of 31 March 2011 contained the statement that 'the Medical Director has responsibility for all risk issues in the Hospital and that there is a clear process for managing risk'. However, at the Board meeting on 30 June 2011, it was requested that this statement be removed from the minutes of the 31 March 2011 Board meeting. At that time, the Acting Chief Executive opposed this amendment stating that "the responsibility for risk within the Hospital lies with the Medical Director". This meeting followed the Authority's announcement of the investigation and the minutes did not record the actions necessary to mitigate this absence of responsibility for the management of risk. Rather, the minutes stated that "further discussion will take place at the September Board meeting" and that "the Board should be satisfied that there is a good corporate governance structure at the Hospital". Minutes of a Board meeting held on 28 July 2011 stated that "the Management Team should prepare a briefing document for the next Board Meeting outlining responsibilities for areas of risk within the Hospital." It was also recorded that a Board member should chair a committee to facilitate the process of the preparation of the briefing document.

9.8.2 Good faith reporting

Effective boards should lead and foster a culture of openness and learning and give priority to ensuring consideration of, and investigation into, any honestly held concern about the standard or safety of the provision of care to patients that members of staff or patient advocates bring to their attention. The Authority found that a number of the Board Members and those in attendance were aware of concerns, raised by the Emergency Medicine Consultants, about risks to the health or welfare of patients arising from care being provided to patients in the corridor adjacent to the ED. The Investigation Team was aware of at least one Board member who met an EM Consultant in relation to these concerns. However, it was indicated to the Authority, that this matter, though raised at some of the Board meetings, was considered as a longstanding practice matter due to capacity deficits in the Hospital and not as a specific health or welfare risk to patients.

The Health Act 2007⁽¹⁾ obliges the HSE to establish procedures to facilitate the making of protective disclosures and for the investigation of any matter that is the subject of a protected disclosure. Individual service providers may, with the agreement of the HSE, also establish procedures for good faith reporting or protective disclosure.

The Authority found that the Hospital did not have sufficiently effective arrangements to facilitate staff to raise concerns about the quality and safety of patient care, nor were there effective arrangements to allow escalation of these concerns to the Board for their consideration. Having such arrangements in place is a fundamental element of establishing a culture of safety in any health or social care service.

There was a structure of, and processes for, governance that did not function effectively at the Hospital. Many governance and patient safety issues required consideration and resolution at a strategic level, although they were rarely considered by the Board or by its clinical governance and audit sub-committees. There was no information about how connections were made between the Hospital's use of resources and the delivery of safe care. For example, it was stated that there had been discussions at the Board in relation to inadequate resources in radiology but that it had come as a surprise to the Board when the news broke in the media in 2009 regarding the reporting backlog in the radiology services. While the Board minutes reflected that the ED featured on the agenda or within the Chief Executive's report, the minutes do not reflect the extent of the discussion and, on occasion, the minutes show the item was deferred.

9.8.3 Information from external sources

Boards should have in place processes that allow them to consider information provided by external sources in relation to the delivery of safe care to patients. This includes information from regulators and the coroner.

The Authority found that, although the Board was aware that the Hospital was in receipt of correspondence from the Authority in relation to concerns about quality and safety, it was not clear that this was discussed in detail. It was stated at interviews that Board Members were notified by email of an impending coroner's case which would likely lead to negative publicity. However, not all of the Board Members were aware of the death of the patient in the ED or made a connection between the concerns of the Authority and the circumstances surrounding this death.

In April 2011, following the death of a patient in the ED, the Authority wrote to the Hospital outlining its concerns about the safety of patients and sought assurances from the Hospital as to how the risks to patients were being assessed and the immediate actions taken to mitigate the risks. The Authority asked the Hospital to provide a copy of the internal review of the case of the death of the patient. At that time, the Authority also sought information as to how the Board was updated on

these risks. Interviewees reported that neither the Board nor the Transitional Board was advised of the details of this particular correspondence and, perhaps, more significantly, the Clinical Governance Committee was not sighted of this letter. The minutes of the 8 June 2011 Board meeting reflect that discussion about the ED was deferred.

In relation to the announcement of the investigation, a number of Board members recounted that they were surprised and felt that the Hospital had been unfairly singled out when the investigation was announced.

There was no record in the minutes that the Board requested the Executive Management Team to provide them with assurances about the quality and safety of care provided to patients who required acute admission and or details about the numbers of patients and the frequency of the use of the corridor to accommodate them.

It became apparent to the Authority, through the investigation's information gathering processes, that the matter of patients being accommodated on corridors outside the ED awaiting admission was accepted as being a normal and longstanding practice. Some Board Members saw this practice, although unfortunate, as acceptable while others, although they did not agree with the practice, thought it a difficult process to resolve. Nevertheless, the Authority found little evidence that the Board challenged the Executive Management Team or the clinicians about the risks to the safety of patients.

9.8.4 Using Information to monitor the quality and safety of care provided to patients

The Board minutes reflected that there was a focus on financial considerations. The routine HealthStat performance reports that went to the Board were at a high level and were focused on measurement rather than on any failings in the care of patients.

Consequently, there was little evidence to suggest that there were systematic arrangements to follow up any actions required or to share lessons.

The minutes of the Board meetings tend to suggest that the Board did not focus on its role to assure the provision of safe high quality care to patients who presented at, or were admitted to, the Hospital. The information provided at interviews amplified the indication given by Board minutes that the Board may have been distracted from patient safety matters as they tried to manage the deteriorating financial position and resolve the governance issues that had been identified in previous reports. The Authority found that the ineffective governance processes and controls rendered the Board as a collective unable to assure itself that the Hospital was a safe place in which to deliver care.

9.9 Board Committees

9.9.1 Introduction to Board Committees

The role of board committees is generally to provide a further level of assurance to a board, through detailed and constructive challenge of an executive management team, by holding them to account across a number of defined and important areas of the business, in accordance with the terms of reference for the committees. In so doing, the committees provide a more detailed level of assurance to the board that effective governance arrangements are in place, risks are being effectively managed and organisational objectives are being delivered within those defined areas and, if this is not the case, to report back to the board. In those circumstances, the board should respond appropriately in requiring the necessary actions of the executive to address any shortcomings and report back to the board.

The *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ states that boards are required to implement Government pay policy as expressed from time to time, in relation to other staff including, as appropriate, the chief executive or equivalent, and other staff of any subsidiary, as relevant. Modern corporate governance would suggest that boards should establish a Remuneration Committee to advise the board on remuneration policies for the chief executive and other senior members of the management team. This committee should compose of Non-Executive Board members only, with executive staff in attendance when required, to assist in determining remuneration packages.

Financial oversight is a key duty of governing boards and is becoming increasingly important in the financially constrained environment. Many of the recommendations and trends in practices related to financial oversight stem from scandals in the areas of corporate governance. In Ireland, for example, the Office of the Comptroller and Auditor General's examination of the internal control and governance in FÁS found, failure to fully implement elements of the plan of internal control meant that FÁS did not have sufficient assurances in place to ensure that its transactions were processed in a safe and regular manner. This exposed FÁS to the risk of losses as well as the risk of failing to achieve best value for money.⁽⁵⁵⁾

The current Department of Finance Guidelines for Corporate Governance for State Bodies⁽⁴⁶⁾ contains a section on the audit committee, which as a sub-committee of the board, should have the responsibility, with management, to review the activities of the internal audit function. Internal audit is a function within an organisation which provides assurances that the risk and control processes are operating effectively, identifies where there are areas of risk and/or poor compliance and make recommendations for improvement where required. The Guidelines outline that the board has direct responsibility for the annual review of the Compliance Register and the Statement of Internal Financial Control as the Audit Committee is itself an element in the overall plan of control. The board should be informed at the earliest opportunity of significant matters identified by

internal audit that may impact on governance, control and accountability and there should be arrangements in place for facilitating timely reporting, including interim reporting where appropriate.

9.9.2 Roles of the Committees

The Charter provided for the establishment of a number of committees which were required to report to the Board of Management in relation to their activities.⁽¹²⁾ Those included the Medical Board and the National Children's Hospital Committee. In addition, the Board established a number of other committees which included the Resources, Audit, Clinical Governance and Nursing Committees. The Transitional Board of Management was also set up as a Committee of the 'Board of Management' in July 2010.

These Board Committees, with the exception of the Transitional Board of Management Committee, had no executive powers but rather advised, reported to and made recommendations to the Board of Management on their activities. The purpose of the Transitional Board of Management was to manage the activities of the Hospital.

There was no Remuneration Committee of the Board. Minutes of the Board Meetings do not record where the remuneration for the Chief Executive and members of the Management Team were discussed. It was not made clear to the Authority how decisions were made at either Board or Committee level in relation to the appointment or remuneration of senior executive managers in designated or acting roles. For example, the governance of decisions to substantially additionally remunerate, in excess of €150,000 in one instance, individual post holders for taking on additional roles was not clear.

In relation to the governance of financial risks, it was not made clear to the Authority as to how the Board monitored the ongoing identification and mitigation of financial risk based on an analysis of the control systems which is essential for the effective administration and utilisation of public money. The Board was aware that there was no complete risk register in place. The Authority found little information as to how the Board or any of its Committees oversaw and assured itself that the Hospital was delivering the services in line with the service plan agreed with the HSE as articulated in the Section 38 Service Arrangement for the resources provided.

There was not clarity among those interviewed about the purpose and roles of a number of the Committees and there appeared to be some duplication and overlap. A review of the minutes suggested that Committees were working at a high operational level and did not have a framework in place to allow them to provide the necessary assurance to the Board. The Authority found that the Board's commissioned review of these Committees by external consultants in

2009, had made similar findings. However, there was no information provided to the Authority to show that any changes had occurred as a result.

9.9.3 Clinical Governance Committee

The Clinical Governance Committee was an advisory committee of the Board and was chaired by a Board member and was accountable to the Hospital Board. This Committee had previously been an executive committee. There were 17 members who included three Non-Executive Board members, one Board member who was a Hospital employee, one Transitional Board member and ten staff members, with three other hospital staff in attendance. Neither the Risk Manager nor the Internal Auditor was a member of this committee although the Risk Manager was in attendance. Its terms of reference included providing assurance to the Board that appropriate clinical governance mechanisms were in place and effective throughout the Hospital.

The Authority found that although the Clinical Governance Committee had a membership of around 17, it was regularly attended by fewer than 10 people. The minutes reflect that the Committee was very operational. This, it was suggested by interviewees, was because there was no corresponding executive committee with an oversight for quality and safety to report to the Committee. Interviews and documents suggest that there was confusion as to who had executive accountability for quality and safety. This was exacerbated by rapid changes in the management structure and roles and responsibilities which had not been reflected in the policies and procedures. At the commencement of the investigation, the Hospital had a draft Hospital's Governance and Quality Improvement Plan (2011 – 2013), and a Quality and Patient Safety Strategy (2010 – 2014). The status of these documents was unclear and it was reported at interview that the implementation of the Quality and Patient Safety strategy, with the proposed revised organisational and reporting structure, was dependent on the appointment of a Director of Quality, Safety and Risk. The appointment of this post was dependent on approval from the HSE. However, at the time of the investigation this post was vacant although the Hospital has subsequently made an appointment to the position.

The Authority found that there were no formal transparent escalation procedures for the Risk Manager or Internal Auditor to escalate concerns to this Committee. Neither were there procedures in place for the Chairperson of the Clinical Governance Committee to escalate concerns in such a way that the Board got immediate sight of concerns from this Committee.

The Authority found that the membership and the terms of reference of the Committee did not facilitate the Committee in seeking assurance from the Executive about the quality and safety of the care being provided to patients. The extensive membership of Hospital staff on a Board Committee meant that the potential for conflicts of interest was built into this system. This does not constitute effective governance. Minutes of meetings reflect that the Chairperson

raised with the Board the need for more data driven reports. It was stated by attendees interviewed that the Committee did not receive any breakdown of incidents or trend reports from the Forum for Adverse Incident Reporting (FAIR) Committee. The Chairperson of the Committee also requested that the Transitional Board consider patient care as one of the first items on the Board agenda.

At the May 2011 Committee meeting, which was only attended by five of the 17 members, the care of patients in the corridor adjacent to the ED in relation to the clinical responsibility for their care was discussed at the end of the meeting under the 'any other business' part of the agenda. It was also recorded in the minutes that a review of the death of a patient was underway and that the Authority had written to the Hospital regarding the ED and that the Executive were preparing a response. However, it was not recorded that these matters were considered as a serious patient safety issue that needed to be addressed immediately. The subsequent Committee report to the Board on 30 June 2011 did not refer to the Authority's concerns.

9.9.4 Resources Committee

The Resources Committee functions included:

- recommending to the Board of Management the policies for the management of the hospital's resources
- ensuring purchasing and procurement policies meet the organisations interests and objectives
- reviewing and recommending to the Board for approval, an annual Business plan for the hospital for the ensuing year, to include activity, finance and human resources
- ensuring management structures and procedures are in place for the identification of the principal risks of the Hospital's operations.

Membership of the Committee included three Non-Executive Board members, three Executive Board members, the Chief Executive and the Director of Finance. The Authority found that the Resources Committee had no executive powers but rather advised, and made recommendations to, the Board of Management in relation to the policies for the management of the Hospital's resources.

The Authority found that the Committee had discussed concerns about the costs of the proposed governance changes and the ongoing reviews throughout 2010. In particular, in August 2010, the Director of Finance reported that the cost drivers for non-pay included €1.8 million for a review undertaken by external consultants and for additional services. A potential end of year cash deficit of €5.8 million and the fact that costs associated with external professional consultancy fees would not be funded by the HSE and would have to be financed from hospital internal resources was recorded in the October 2010 minutes. In addition, these minutes indicated that the Hospital's internal auditor was reviewing the background to the

initiation of the €1.8 million consultancy services. However, the Authority did not find in later Resources Committee minutes reviewed as part of the investigation any further reference to this internal audit.

The Authority did not find records or minutes tending to show how the Resource Committee ensured purchasing and procurement policies, particularly in relation to the procurement of consultancy services, met the organisation's interests and objectives.

The Resources Committee's role was to review and recommend to the Board for approval, an annual Business Plan for the Hospital to include activity, finance and human resource. It was not made clear to the Authority as to how the Resource Committee discharged this role. In addition, it was not clear how the Committee ensured that the management structures were in place for the identification of the principal risks of the Hospital's operations or provided assurances to the Board in relation to this.

9.9.5 Audit Committee

The Authority found that the Terms of Reference for the Audit Committee stated that the Committee advised and made recommendations to the Board of Management in relation to the effectiveness and impact of all internal controls in the Hospital, compliance by the Hospital with legal and regulatory requirements, independence and performance of the Hospital's external and internal auditors and the integrity of the financial statements and other activity data produced by the Hospital. The Terms of the Reference of the Audit Committee included the authority of the committee, its composition and responsibilities, including a set of disclaimers which outlined the limitations of the committee, and the roles of management, internal auditors and external auditors in supporting the Committee in its functioning.

Membership of the Committee included two Non-Executive Board members, one Executive Board member and two other external members. The Terms of Reference did not specify which of the Hospital's Executives was to be in attendance. It was not made clear to the Authority as to how the Committee fully discharged its role. The minutes of the Audit Committee and the Board recorded decisions made, rather than details of the discussion which took place. Therefore, the Authority was unable to ascertain from the minutes of the Audit Committee or Board meetings the level of discussions which took place in relation to the effectiveness and impact of all internal controls in the Hospital.

This lack of transparency is of concern in an organisation that was in annual receipt of over €180 million of public funds, and in particular, given that there was a significant budgetary overrun in 2010.

The Authority's review of Board Minutes showed that reports of Audit Committee minutes were circulated to Board members. The Authority found that on a number

of occasions, the reports were circulated at the time of the Board meeting or that discussions were deferred due to time constraints.

The Authority reviewed the minutes of the Audit Committee for 2010 and 2011. It was noted that, further to queries being raised by the Audit Committee in May 2010 and June 2010, it was confirmed to the Audit Committee in September 2010 that a total of €1,810,326 had been incurred for third party management consultancy and professional fees between January and July 2010. It was stated in the minutes that the costs related, amongst other things, to a review of the efficacy of the corporate and clinical governance arrangements at the Hospital in response to the significant patient safety risks identified in relation to the unreported X-rays and the unprocessed GP letters. The Audit Committee minutes dated March 2011 highlighted their concerns in relation to the process and cost of this corporate and clinical governance review.

In addition, the Audit Committee expressed concerns that the consultancy application had not come before it. Consequently, the Audit Committee escalated the issue to the Board on 30 September 2010 and, at that time, the Board of the Hospital urgently requested an internal review of the costs aligned to these third party consultancy fees.

The Audit Committee minutes of the 14 June 2011 recorded that the Committee reviewed a draft copy of its internal audit review of the consultancy fees. This draft internal audit found that the procurement of this consultancy had not followed the formal procurement process and procedure, the work was not put out to general tender and identified issues of concern including contract management and monitoring practices.

Public procurement legislation,⁽⁵⁶⁾ and the HSE's Section 38 Service Arrangement⁽⁴⁸⁾ with the Hospital, govern the procurement of consultancy services. Minutes of a meeting between the Hospital and the HSE in July 2010 recorded that the HSE advised the Hospital that it would not fund external consultancy.

The Authority found that the Hospital entered into a contract for the provision of consultancy services (which was of indeterminate value when it was entered into) to review the governance arrangements without reference to the Audit Committee or Resources Committees. The awarding of this contract of indeterminate value subsequently led to consultancy fees of approximately €1.6 million being incurred and did not follow the required tendering or procurement procedures.⁽⁵⁶⁾ There was no evidence provided to suggest written quotations were sought or tenders invited from other interested parties for this work.

The Hospital's 2010 audited Financial Statement, which was signed off on 29 September 2011, stated that there was a cost of €1,810,326 assigned to once off consultancy charges in relation to clinical governance and organisational change. This Statement also indicated that there was a deficit of funding over net expenditure to the amount of €20,537,883 carried forward to 2011.

The Authority found that the Audit Committee did not have effective governance arrangements, including internal controls or procedures, in place to detect non-compliance with the required tendering or procurement procedures in a timely way. In addition, the Committee did not respond in a sufficiently timely way, to the concerns raised about the accrued consultancy costs. This, the Authority found, was in the knowledge that at a meeting in July 2010, the HSE had advised the Hospital that it would not provide additional funding for these external consultancy costs. Also of significance was the fact that, at that time, the Hospital was forecasting a 2010 deficit of €7.2 million.

9.9.6 Governance Reviews

The *Code of Practice for the Governance of State Bodies*⁽⁴⁶⁾ states that Boards should review its own performance and that of its committees and individual directors.

Concerns about the governance arrangements were raised by some members of the Board in 2009. The Authority found the newly appointed Chairperson of the Board obtained the Board's consent to commission an external review of the corporate governance. This 2009 review by external consultants of the *Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ identified a number of over-arching issues most of which had their origins in the governance and management arrangements that were put in place at the time of the Hospital's establishment to accommodate the merging entities and were an impediment to effective decision making. It recommended a radical restructuring at Board and senior management level.

The external consultants recommended that the size of the Board be reduced from 23 to a more manageable 8 to 12, with the introduction of Non-Executive Directors with the appropriate skills and experience and a clear definition of the respective roles of the Board and senior management of the Hospital. However, it was stated at interviews that despite approving the recommendations at a Board meeting in October 2009, there was not universal agreement with the findings and not all the Board Members agreed with the proposed changes.

The announcement in 2010 of the review of radiology reporting and the management of GP patient referral letters at the Hospital was reported as a catalyst for change.⁽²⁾ At the March 2010 Board Meeting, the Chairperson of the Board circulated a proposal for the creation of a Transitional Board of Management on foot of a review of the 2009 *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ which he had engaged external consultants to conduct. The Chairperson briefed the Board of the main issues identified in the Review and following considerable negotiation with members of the founding organisations, and legal advice, the Board agreed to the establishment of a Transitional Board of Management as a sub-committee of the Hospital Board. This committee was proposed to have a tenure of one

year, during which time it was anticipated that the structural changes, including an amendment to the Charter to bring the governance of the Hospital in line with modern governance principles, would be implemented.

The Hayes Report 2010⁽²⁾ identified that there were systemic weaknesses at management level and that the Board level structures were not sufficiently robust to provide the level of governance, supervision and direction required in the management of a large and complex organisation with an ever increasing demand for services. The Report found that issues in relation to the handling of x-rays and GP patient referral letters were symptomatic of wider structural and systemic weaknesses at management and Board levels which related to the governance arrangements in place, management structure, reporting systems, lines of responsibility, risk management arrangements, communication and human relations. This Report also found that despite initiatives being taken at various times, the governance arrangements in place were not effective in ensuring that specific problems were effectively addressed. It acknowledged that the issues identified had already been the subject of a report and recommendations of management consultants (*Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾) which the report fully endorsed. In particular, the Hayes Report⁽²⁾ agreed with the management consultants' recommendation that the size of the Board be reduced from 23 to between 8 to 12, with the introduction of Non-Executive Directors with appropriate skills and experience and a clear definition of the respective roles of the Board and senior management of the hospital. The report also recommended representation should be included on the Board of a local GP and of a member of the community. It was recommended that there should be training for all Board members regarding the requirements of their role under corporate governance and on fiduciary and other responsibilities of Board members. The need to strengthen the Board and committee structures rapidly was highlighted as was the development of risk management and quality controls.

In July 2010, at a special meeting of the Board, the agenda and minutes reflect that the management consultants and external auditors presented on transformation, performance management, quality and risk, risk analysis and Board Assessment. The minutes of this meeting reflect that the Board ratified the implementation of a plan based on the findings of the *Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*⁽³⁾ that had previously been approved by the Board in October 2009.

9.9.7 Transitional Board

The Transitional Board of Management was established as a Committee of the Board in September 2010. However, this Committee was not identified in the diagram depicting the Board's governance structure submitted to the Authority. Its

purpose was to manage the activities of the Hospital by exercising the Executive Functions of the Charter which were delegated to it by the Hospital Board as set out in its Terms of Reference for an initial period until 31 July 2011. The Hospital Board retained the legal responsibilities for managing activities of the Hospital including the Executive function.

The Board appointed the 11 members of the Transitional Board of Management with the membership proposed as follows: Chairperson of the Board, Chief Executive, nominees from the Adelaide Hospital Society, the Meath Hospital, the National Children's Hospital, Trinity College, Dublin, the President of the Hospital, three individuals who represented patient interests, business/financial expertise, and quality control/safety and a staff representative.

The Terms of Reference set out that the Transitional Board of Management would report to the Board at least quarterly and would be accountable to the Board. Minutes of all meetings were copied to the Board members once approved and the Transitional Board of Management presented a written report and oral presentation at each meeting of the Board. The Transitional Board of Management schedule and meeting minutes indicated that they met seven times between January and July 2011 with a quorum of six in attendance. The Chairperson of the Medical Board and the Clinical Director were invited to attend these meetings. The Terms of Reference also identified that the Transitional Board of Management would receive and review written/oral reports from the Chief Executive and senior managers as well as from the Clinical Governance and Resources Committees of the Hospital Board.

However, this created duplication. It was reported that the Clinical Governance, Resources Committee, Audit Committee, Nursing Committee and the National Children's Hospital Committee also presented their written/oral reports directly to the Hospital Board at its meetings. It was suggested by some interviewees that in reality, the Transitional Board and the Hospital Board debated similar issues which were mainly regarding finance and the proposed governance changes.

The Authority found that the lines of accountability between the Executive Management Committee, the Transitional Board, the Hospital Board and the Clinical Governance Committee were not clear. It was also stated by a number of those interviewed that not all staff were aware of their lines of accountability at individual, team and service levels. In particular, it was reported during interview by some members of the Transitional Board that there was disparity about who had overall executive and operational accountability for quality and safety at the Hospital.

The acting Chief Executive provided reports which included a section on risks and outlined some matters of patient safety including updates on the implementation of the Hayes Report and issues in relation to Data Protection. The acting Chief Executive advised the Transitional Board on 25 May 2011 of the concerns raised by the Emergency Medicine Consultants in relation to the care of patients in the

corridor adjacent to the ED. The Transitional Board requested an internal review of the "Clinical governance model for patients admitted to the hospital and located in the 'Virtual Ward' situated within the ED" with a report to be provided by the June 2011 meeting. This report was received by the Authority as part of the data gathering after the commencement of the investigation. The Report concluded that the temporary placement of patients on the "virtual ward", the ED corridor adjacent to the ED, was "sub-optimal for patient care" and should not be accepted. It identified that there were "considerable risks to the provision of safe care for patients". The review made a number of preliminary recommendations which included the:

- use of standardised nursing documentation and patient care plans
- appointment of a nurse to coordinate the care provided for admitted patients awaiting transfer to an inpatient ward
- introduction of the national clinical care programmes
- recruitment of additional allied health professional and specialty nursing staff
- enhancement of bed management processes.

In addition, the report identified that the Hospital must, as an absolute priority, work with the HSE in addressing the risks associated with boarding patients in the Emergency Department.

However, the minutes do not reflect that the Transitional Board was sighted of the final report or of correspondence from the Authority in relation to its concerns about patients being cared for in the corridor. In particular, the minutes of the Transitional Board meetings do not record the Transitional Board being advised that the Authority had sought assurances from the Hospital as to how the risks to patients were being mitigated following the death of a patient in the ED.

The term of the Transitional Board had ceased prior to the commencement of the investigation.

9.10 Risks relating to governance

During the course of the investigation, a new Chief Executive was appointed in August 2011 and the term for the 2008 to 2011 Board was completed in July. At that time, the Authority sought, but was not provided with, the proposed membership and structure of the new Board, as final agreement had not been reached.

However, in October 2011, having substantially concluded the main investigative part of the investigation process and based on the emerging and preliminary findings of the investigation, the Authority had significant concerns in relation to the effectiveness of the corporate and clinical governance arrangements in place at the Hospital and, in particular, the effectiveness of the Board governance arrangements. These concerns were such that it was the view of the Authority that the absence of these effective arrangements had the potential to pose a serious risk to the health or welfare of some patients receiving care at the Hospital.

The Authority was also concerned, based on its preliminary findings, that the new Board would not have the relevant knowledge, skills and competencies required of an effective Board or the type of Non-Executive experiences required to support the Hospital through the challenges that it was facing. The Authority was also concerned that the lack of sufficiently effective Board governance arrangements had the potential to compromise any short-term gains made following the appointment of the new Chief Executive. Consequently, the Authority met with the Minister for Health to advise him of these concerns.

Subsequently, following these meetings, the Authority wrote to the Minister for Health, on 18 November 2011, (see Appendix 10) advising that the Authority, having considered the preliminary evidence gathered and analysed at that time, had identified potential serious and urgent risks in relation to the lack of effectiveness of the Board governance arrangements in place at the Hospital. In view of the serious nature of the concerns, the Authority also provided the Minister with a number of the Authority's emerging preliminary draft recommendations to help mitigate the identified risks at that time whilst emphasising that these may change by the time of the publication of the Report of the investigation. The preliminary draft recommendations were as follows:

- In order to effectively lead, govern and stabilise the significant financial management and quality and safety challenges, and the deficits in governance and management that need to be addressed in the Hospital, there is an urgent need to have an effective governing Board in place that is appointed independently and solely on the basis of competence and experience to effectively fulfil the role.
- The Board should consist of twelve persons (inclusive of the Chairperson) who are appointed through an independent process for Board appointments that is established by the State. In advance of such an independent process being established, the members of the Board should be appointed by the Minister for Health solely on the basis of such competence and experience as stated above. Individuals with conflicts of interest, including employees of the Hospital and those with other relevant conflicts of interest, should not be appointed to the Board.

- If there are undue delays in constituting the Board as above, an interim arrangement should be put in place, as a matter of urgency, that ensures that individuals with the relevant non-Executive experience and competencies in organisational turnaround and strategic management, are formally incorporated into the membership of the Board with full voting rights and the necessary authority to lead the Board and support the Chief Executive in leading the organisation through the current challenges.
- The Hospital, with the support of the Minister and Department of Health, should establish an engagement mechanism through which the Foundations that have been actively involved in the management of the Hospital to date, can continue to engage with the Hospital in a non-governing and non-managerial role and continue to inform and shape the future direction of the Hospital with the best interests of the public at heart.

The final recommendations, following the conclusion of the investigation, which relate to these areas, are outlined within this section of the Report.

Around that time, in addition to the significant legacy deficit, there were also substantial financial difficulties at the Hospital resulting in a position of significant budgetary overrun and the risk of the Hospital exhausting their funds prior to the year end.

On 9 November 2011, the Minister for Health, and the Church of Ireland, Archbishop of Dublin, announced a series of new initiatives to reform and modernise the governance structures of the Hospital over two phases. The first phase was a further reduction in the size of the Hospital Board through the appointment of an interim Board and, in the longer term, the Charter was to be replaced.

In December 2011, the Minister for Health appointed Sir Keith Pearson, Chairperson of the NHS Confederation in the United Kingdom, as the interim Chairperson of the interim Board at the Hospital. While Sir Keith Pearson had been a member of the Authority's Investigation Team, his tenure on the Investigation Team had ceased prior to this appointment. The first meeting of the new interim Board of the Hospital took place on 21 December 2011 with new members of the Board being nominated with consideration of their competencies to undertake the role.

In addition, during the course of the investigation, information came to the attention of the Authority that raised concerns about the effectiveness of the governance arrangements in place for financial management, financial transparency and commitment control. In particular, the Authority was concerned that the Hospital might not have had the internal controls in place to ensure its compliance with public procurement legislation. The Authority also had concerns about the HSE's budgetary and performance oversight of the Hospital in accordance with the funding arrangements for the Hospital by the HSE, pursuant to Section 38 of the Health Act 2004⁽⁴⁸⁾ as amended.

Consequently, on 24 February 2012, the Authority wrote to the then Comptroller and Auditor General (see Appendix 11) advising that the Authority, having considered the evidence gathered and analysed at that time, had identified potential serious risks in relation to the lack of effectiveness of the governance arrangements in place at the Hospital.

9.11 Conclusions

9.11.1 Board Governance

Since 2009, the governance of the Hospital had been the subject of both internal and external scrutiny. In 2009 there was an internal review, (*Review of the Appropriateness and Effectiveness of the Governance and Senior Management Structures at AMNCH*)⁽³⁾ and in 2010 an external review (Hayes Report).⁽²⁾ The Authority also focused on the governance, in particular, that of the quality and safety of care provided to patients. All of these concluded that the governance arrangements were ineffective.

The Authority found that the Board of the Hospital did not have effective arrangements in place to adequately direct and govern the Hospital nor did it function in an effective way to oversee the safe delivery of care to patients. The Charter⁽¹²⁾ was not in line with modern corporate governance principles. However, notwithstanding the Charter, there was nothing to preclude the Board from implementing the arrangements necessary to effectively govern the Hospital.

The collective membership of the Board did not reflect the relevant diversity of knowledge, skills and competencies required to carry out the full range of oversight responsibilities necessary for the Hospital at this juncture. Nor was the appointment process in line with modern governance principles.

The amalgamated organisation which was merged in 1996, continued to embrace a number of different legacy beliefs, activities and cultures, lacked an organisation-wide strategic vision and culture and failed to adequately respond to the significant changes in healthcare delivery and advances in modern corporate governance.

Patient safety should be on the agenda of every hospital board meeting. A board should receive reports that provide assurances that risks to the safety of patients are being managed. A board can delegate this function to a committee of the board. However, a board cannot delegate its overall accountability and responsibility for the safety of patients.

The Board must move from micro management of the Chief Executive to a position of defining the long term strategy, securing a business plan to deliver that strategy and then holding the Executive to account by assuring themselves that the business plan is delivered. The Board needs to be far more in tune with the healthcare environment in which their services are being delivered, an environment in which quality, safety and outcomes must drive thinking and where patients are at the heart of everything they do.

The Clinical Governance Committee at the Hospital was a committee of the Board charged with providing assurance to the Board that clinical governance in the hospital is effective. A clinical governance committee needs to be driven through a proper alignment to the risks and emerging evidence of risk and should be alerting the board when they feel the board does not have a line of sight to potential poor governance and risk management. The committee needs to create distance from the issues such that they can take an entirely independent view. This was not the case in the Hospital.

The Audit Committee was a Committee of the Board charged with providing advice and making recommendations to the Board of Management in relation to the effectiveness and impact of all internal controls in the Hospital, compliance by the Hospital with legal and regulatory requirements, independence and performance of the Hospital's external and internal auditors and the integrity of the financial statements and other activity data produced by the Hospital. The Authority found that the Audit Committee did not have sufficiently effective internal controls or procedures in place to detect non-compliance with the required tendering or procurement procedures.

Board governance is about vision and organisational direction as opposed to the implementation of strategy and the day-to-day management of a hospital's activities. Effective assurance, stewardship and fundamental governance are essential and from the findings of the Authority, these were not sufficiently present or effective in the Board of the Hospital.

As a result of these findings, during the investigation, the Authority wrote to the Minister for Health (Appendix 10) outlining a number of serious concerns that it had identified from the preliminary findings of the investigation at that point. The Authority indicated that given the significant quality and safety challenges, the financial shortfall and the need to rebuild patient confidence that were being faced by the Hospital, there was an urgent need to have an effective governing Board (Chairperson and Non-Executive Directors) in place to effectively lead, govern and support the Chief Executive and the Executive Management Team to direct and manage these challenges.

The governance at the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital needs to change. The current Charter is not in keeping with modern corporate governance and should be replaced by the necessary legislative means to establish a fit for purpose Board that will be constituted in such a way as to be enabled to drive the necessary changes required. The primary function of the first newly appointed Board, will be to effectively lead, govern and stabilise the significant financial management and quality and safety challenges, and the deficits in governance and management that need to be addressed in the Hospital. With the right leadership, future boards will then be able to strategically lead and oversee the evolution of the Hospital into a strong, high quality provider for its community well into the future.

In view of the significant governance improvements required, a substantive Board of an appropriate size should be appointed as a matter of urgency, and following the dissolution of the current interim Board. This should be comprised of Non-Executive Directors and a Chairperson and, in keeping with good governance, should not contain employees of the Hospital. The Chief Executive, and other nominated Executive Officers (to include the equivalent of the Director of Finance, Medical/Lead Clinical Director and Director of Nursing) should be formally in attendance at the Board with combined shared corporate accountability for the effective governance and management of the Hospital.

It is essential that all Non-Executive Directors who are appointed to the Board are appointed through an independent process that is established by the State and with the necessary skills, experience and competencies required to fulfil the role effectively. It is vital that the next Chairperson of the Board who is appointed has extensive and demonstrable experience in successfully chairing the Board of a challenging organisation(s), is an effective strategic leader and has strong corporate governance experience. The individual must also have the gravitas and expertise to, together with the Chief Executive, further build and establish strong relationships with key stakeholders and implement the effective turnaround of the governance, management and leadership of the Hospital.

Given the historical commitments of the Foundations, and the need for the Hospital to engage with its community and wider stakeholders, it will be important for the current interim Board, and the newly established substantive Board, to develop a mechanism by which these important stakeholders can be involved in the future development of the Hospital in a non-governing and non-managerial way.

9.11.2 National perspective

The Authority is aware that the design and legislative basis of current boards, and the composition of their membership, varies across the country. In order to ensure that hospitals are led and governed effectively, and in a way that reflects the modern day requirements of good corporate and clinical governance in a quality and safety driven sector, it is essential that the membership, competencies and focus of a board are suitable for this purpose. The Authority has outlined good practice in relation to the competencies and outcomes that it would expect to see from an effective board. These can be found in Appendix 12.

With the increasing need for effective corporate and clinical governance in health and social care organisations, undertaken in an open and transparent manner particularly where the organisation is funded from State funds, the Authority has made recommendations below to ensure that good governance is in place in existing established Boards and Executive Management Teams of such organisations.

The boards and executive management teams of current healthcare organisations in receipt of State funds should review the effectiveness of the corporate and clinical governance arrangements in place, including the size, composition and competency of the board and executives within their organisation, and the process for the appointment to board vacancies, in order to satisfy themselves that they are consistent with these recommendations and develop and implement an action plan to meet them accordingly. A process to assess these reviews and monitor the implementation of the action plans should be established and undertaken by the Department of Health.

The implementation of these recommendations for all healthcare service providers in receipt of State funds will subsequently be used to inform the Authority's monitoring programme for the *National Standards for Safer Better Healthcare*⁽⁵⁾ when approved by the Minister for Health, and are consistent with the direction towards the licensing of healthcare facilities in the coming years.

Recommendations have been made for the effective corporate and clinical governance arrangements of existing boards and executive management teams of healthcare service providers. Given the policy direction of establishing 'Hospital Groups' of HSE and/or other State funded facilities, and the subsequent move towards self-governed Trusts (or equivalent), recommendations have also been made to shape and direct the successful development and implementation of this policy.

With the move towards a more structured framework and behaviour for the corporate and clinical governance requirements of boards, the role of a board member, in some organisations, may need to move from a more informal and voluntary participation to the professionalisation of board members. In consideration of this distinct change in corporate accountability, the Minister for Health should consider whether the remuneration of board members of service providers in receipt of State funds to discharge such functions is required. In order for board members in receipt of remuneration to contribute effectively in their role, a stronger performance management of board members should be introduced that may include the capitation of remuneration based on a defined percentage of the remuneration allocated as a core fee and the remainder based on the assessment of the board member by the Chairperson within a performance criteria that includes attendance and contribution.

Given the substantial amount of public money that is entrusted to service providers that are in receipt of State funds, there should be greater involvement in the performance management of the Chairperson by the State, for the purpose of holding the Chairperson and the Board accountable for the provision of well governed and effectively managed services and in relation to the appointment, performance and termination of the Chief Executive. This should be through a line management relationship of all Chairpersons of hospitals (in the first instance) in receipt of State funds to a nationally designated post holder (this may be, for example, the Chief Executive or future Director General of the new HSE structure or equivalent).

The Minister for Health should consider adopting a similar approach for the line management, performance delivery and accountability arrangements in place for Chairpersons and Chief Executives, as outlined in section 10.4.2, across the wide range of health and social care providers in receipt of State funds. In these cases, the reporting lines will most appropriately reflect the sector concerned and consideration of such arrangements should also be given in future policy developments that are put in place for areas such as primary care.

Recommendations – Board Governance

Governance Arrangements of Boards

1. The Charter should be replaced by the necessary legislative means to establish a fit-for-purpose Board.
2. The current AMNCH Interim Board should be dissolved in the coming months, and, through a managed transition, a new substantive Board should be appointed.
3. The Department of Health should ensure that any required legislative amendments to the constitution of existing healthcare organisations in receipt of State funds take account of these recommendations.
4. All health and social care service providers in receipt of State funds should ensure their compliance with the *Code of Practice for the Governance of State Bodies*.
5. The chairpersons of all hospital boards (in the first instance) in receipt of State funds should be line managed by a nationally designated post-holder for the purpose of holding the chairperson and the board accountable for the provision of well governed and effectively managed services and in relation to the appointment, performance and termination of the chief executive (this post-holder may be, for example, the Director General of the new HSE structure, or equivalent).
6. All health and social care service providers in receipt of State funds should come under the remit of the Comptroller and Auditor General and should be compliant with all directives from the Departments of Finance and Public Expenditure and Reform (particularly in relation to finance, procurement and staffing).
7. A mechanism should be established through which Foundations, Trustees and other community stakeholders, can continue to be involved in the development of hospitals in a non-governing and non-managerial way.

8. The establishment of boards of 'Hospital Groups/Networks' should be in accordance with the recommendations of this Report.

Board Structure and Composition

9. Boards should be of a sufficient size (up to a maximum of 12) and expertise to effectively govern the organisation. The board should be selected and appointed through an independent process established by the State and on the basis of having the necessary skills, experience and competencies required to fulfil the role effectively. The board should comprise non-executive directors and a chairperson and, in keeping with good governance, individuals with conflicts of interest, including employees of the hospital and those with other relevant conflicts of interest, should not be appointed to the board. The chief executive, and other designated executive officers (to include as a minimum, the equivalent of the director of finance, medical/lead clinical director and director of nursing) should be formally in attendance at the board with combined shared corporate accountability for the effective governance and management of the hospital.

In advance of such an independent process being established, the members of boards with the necessary knowledge, skills, competencies and experience should be appointed by the Minister for Health.

10. The Minister for Health should consider introducing remuneration of members of boards of organisations that are in receipt of State funds. A stronger performance management of board members should be introduced with consideration of the capitation of remuneration based on a defined percentage of the remuneration allocated as a core fee and the remainder based on the assessment of a board member by the chairperson within a performance criteria that includes attendance and contribution.
11. Existing boards should undertake an assessment of the composition, competency profile and potential conflicts of interest of board members and make the necessary changes required to ensure that the board is constituted appropriately and in accordance with modern day corporate governance of boards and the recommendations contained in this Report.
12. Existing boards of hospitals should consider replacing current and future vacant board director positions by using the independent process established by the State.

13. A mandatory board induction programme should be in place for all new board members, and executive directors, covering such topics as the role and responsibilities of a board member, the role and responsibilities of executives, corporate and clinical governance, financial oversight, ethics and business conduct and their roles and responsibilities in achieving board objectives specific to the organisation.
14. There should be a mandatory ongoing development programme for board members, informed through the annual self-evaluation of the effectiveness of the board, covering topics such as emerging governance issues and practices, quality and safety and financial management as well as more detailed information on organisation-specific issues.

Conducting Business of Boards

15. The role and functions of boards must be clearly defined and the board should:
 - ensure that there is an effective management team in place
 - oversee the development of, approve, and monitor the implementation of the hospital's strategic plan
 - ensure that there is an effective code of governance in place that is subject to ongoing review
 - require the executives to provide concise, understandable and relevant information that demonstrates that the hospital is achieving its strategic objectives, effectively managing its available resources and providing good, safe care
 - challenge the executives of the hospital when it is not clear that the hospital is achieving its objectives, and hold executives accountable for performance
 - provide assurances to the public that the service is managing its resources to provide sustainable safe, effective person-centred care
 - oversee and approve the development of the hospital's quality, safety and risk management plan and regularly evaluate the hospital's risk register and risk management activities
 - monitor rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the hospital, and also inform action that may be required to improve outcomes for patients.

- 16.** Board members should understand:

 - their fiduciary duties to act as members of the board of an organisation and not representatives of any group
 - their equal responsibility for the consequences of the board's decisions, actions or non-actions
 - the need to support and abide by decisions made by the board even if, as individuals, they did not participate in the decision or did not agree with the decision.
- 17.** There should be a register of interests in place in relation to individuals with potential and/or actual conflicts of interest, in accordance with the requirements of the Ethics in Public Office Act, that includes board members and employees of the hospital and those with other relevant conflicts of interest. This should be subject to no less than annual review by the chairperson and chief executive.
- 18.** There should be an effective process in place for board members to declare potential and/or actual conflicts of interest whilst conducting board business that would allow the chairperson and board secretary to consider for themselves if there were agenda items that might possibly present a conflict of interest for any member of the board. All potential and/or actual conflicts that arise and decisions in relation to them should be documented.
- 19.** Boards should oversee and support the building of strategic partnerships with other stakeholders, including community organisations, primary and secondary care providers, in order to achieve the organisational objectives and to ensure that the organisation does not operate in isolation of the national and local system for the delivery of care and support to its population.
- 20.** A board should have access to the appropriate information in order to fulfil its role of effectively governing the delivery of high quality, safe and reliable healthcare. This should include the development of a quality and safety assurance framework with key performance indicators (KPIs) to assure patient safety, patients' experience, access and financial management. Every board should use these KPIs and other quality and safety information to assure itself about the quality and safety of care being provided and publish this information.
- 21.** A clear scheme of delegation of accountability from the board to chief executive and executive directors should be in place. This should include unambiguous delegated executive accountability and responsibility for the quality and safety of patient care.

- 22.** The board should ensure that the scheme of delegation for critical decision-making, including financial thresholds and policy decisions, is clear and unambiguous and is subject to no less than annual review by the board.
- 23.** The business of boards in receipt of State funds should be conducted openly and transparently. All boards should hold the maximum amount of their board meetings in public by June 2013 including conducting an annual general meeting in public from 2013.
- 24.** Boards should carry out an annual self-evaluation of the board, chairperson and board members, board committees, board operations and implement any improvements identified.
- 25.** Boards should put in place arrangements to facilitate staff to raise concerns about the quality and safety of patient care, and to allow escalation of these concerns to the board for their consideration.
- 26.** Boards should have in place processes that allow them to consider information provided by external sources (including from patient advocates) in relation to the delivery of safe care to patients.
- 27.** The existing boards of healthcare organisations in receipt of State funds should review the effectiveness of the corporate and clinical governance and management arrangements in place in the organisation in order to satisfy themselves that they are consistent with these recommendations and develop and implement an action plan to meet them accordingly.
- 28.** The chairperson must be accountable for ensuring that there are annually agreed objectives in place for the chief executive that accurately reflects the realm of their accountability, responsibility and authority.
- 29.** The chairperson must be accountable for ensuring that there is an effective process in place to support, develop and manage the performance of the chief executive. This process should incorporate the views of the Director of Hospital Care (or other designated individual) and other key stakeholders and should be undertaken by an appropriate committee of the board. Where there are issues of poor performance, the chief executive should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.

10 Executive Management

10.1 Introduction

An effective executive management team ensures that a hospital fulfills its operational functions aligned to their strategic direction by planning, controlling and organising the service to achieve its outcome in the short, medium and long term. In order to achieve this, it is necessary that there is an effective and competent chief executive, and executive management team, to lead, manage and integrate the inter-dependencies between the organisational arrangements and clinical services in order to deliver high quality, safe and reliable patient care.⁽⁵⁾

The organisation should have formalised governance arrangements with clear lines of delegated accountability and responsibility at chief executive, executive director, healthcare professional, managerial and other staff levels thereby ensuring that everyone is aware of their respective role and responsibilities.

The features of effective executive management arrangements includes:

- a competent and effective chief executive with overall delegated executive accountability, responsibility and authority to deliver high quality, safe and reliable healthcare and who is able to work effectively with the chairperson
- an executive governance structure that effectively manages and integrates the corporate and clinical functions
- a clear scheme of delegated accountability and responsibility to members of the executive team and other senior managers
- having effective arrangements in place to monitor and manage the performance of the service, and individual staff members, against clear business objectives and key performance indicators, including resource management and the quality and safety of the services, and reporting this through the relevant governance structures
- establishing effective arrangements in place with external agencies as appropriate, holding these subject to ongoing review and reporting on this performance through the relevant governance structures
- establishing effective arrangements to plan and manage service change, increase in service demand and transition effectively, within the available resources

- actively promote and strengthen a culture of, learning, quality and patient safety
- proactive identification, management, reduction and elimination of risks including clinical, safety and financial risks
- establishing a proactive approach to learning from findings and recommendations from local, national and international investigations and recommendations.

10.2 Executive management

As previously referenced, in 2009, the Board had commissioned a corporate governance review in relation to the governance and management arrangements at the Hospital.⁽³⁾ The review noted the disparity that existed in the context of the Hospital Charter⁽¹²⁾ whereby hospital staff nominated to the Board by any of the three foundations may already hold a hospital management role. Consequently, the review made two specific recommendations to the Hospital Board in October 2009 which were to define the:

- Board function vis-à-vis the Hospital's management role
- decision-making powers of the Management team members and put systems in place to ensure their authority is not compromised.

These recommendations were endorsed in the Hayes Report.⁽²⁾ At the time of the investigation, it was reported at interview by a number of clinical and managerial staff that the authority of the Executive Management Team and its members was often undermined by subsequent decisions taken at Board level. In addition, the Authority found no clear evidence to suggest that the above recommendations had been implemented at Board level.

At the time of the investigation, the Charter⁽¹²⁾ did not identify the office or role and functions of the Chief Executive. In addition, the Authority found that there was no formal scheme of delegation from the Board to the Chief Executive or the Executive Management Team for delegating accountability in relation to functions. In practice, this meant at the time of the commencement of the investigation, that the Hospital Board did not formally delegate the executive management function to the Chief Executive Officer of the Hospital. Consequently, the Hospital Board formally retained the dual function of governance and executive management to include quality and safety arrangements. This is not in accordance with effective corporate governance.

At the time of the commencement of the investigation, the acting Chief Executive was chairperson of the Executive Management Committee, had been a member of the Transitional Board, a sub-committee of the Board and was in attendance at the Hospital Board. There were senior clinical and managerial staff with responsibility and accountability who reported directly to the post holder. However, a number of the clinical staff were also members of the Board whereas the acting

Chief Executive reported to the Board. In addition, the Authority found that both at an Executive and Board level there was a lack of clarity about which post holder had executive responsibility for quality and safety.

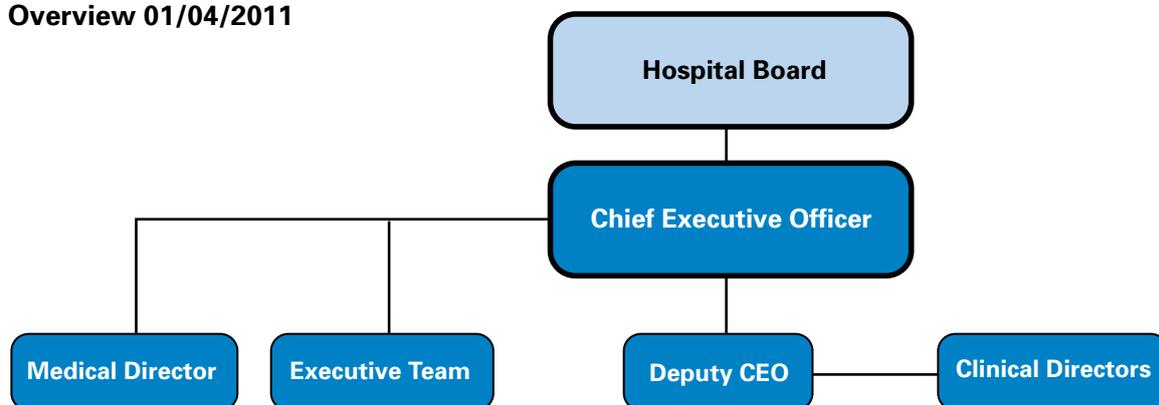
10.2.1 Executive management structure and composition

Since the Authority's initial engagement with the Hospital, a number of different organisational charts have been presented identifying the lines of accountability and responsibility. There were a number of diagrams depicting the organisational structure provided to the Authority. These included a representation of the Hospital's Corporate Governance (Figure 9) and the Clinical Governance structural arrangements (Figure 10). These representations were not aligned with the Board Governance representation and demonstrate the confused governance structures in place at the commencement of the Investigation.

Figure 9: Corporate Governance Structure at Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH)

AMNCH Corporate Governance

Overview 01/04/2011



Source: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

At the time of the commencement of the investigation, members of the Executive Committee consisted of the acting Chief Executive, acting Deputy Chief Executive who was also the Director of Nursing, interim Director of Performance and Planning, acting Director of Finance, acting Director of Human Resources and the lead Clinical Director. For a period of time, despite this post being advertised internally, there was no representation from the Clinical Director because the post-holder had retired and no replacement had been appointed. In addition, the Medical Director was not a member of the Executive Committee. Five of the six positions were not formalised, and with staff in acting positions together with the absence of clinical input, this should have alerted the Board as to the

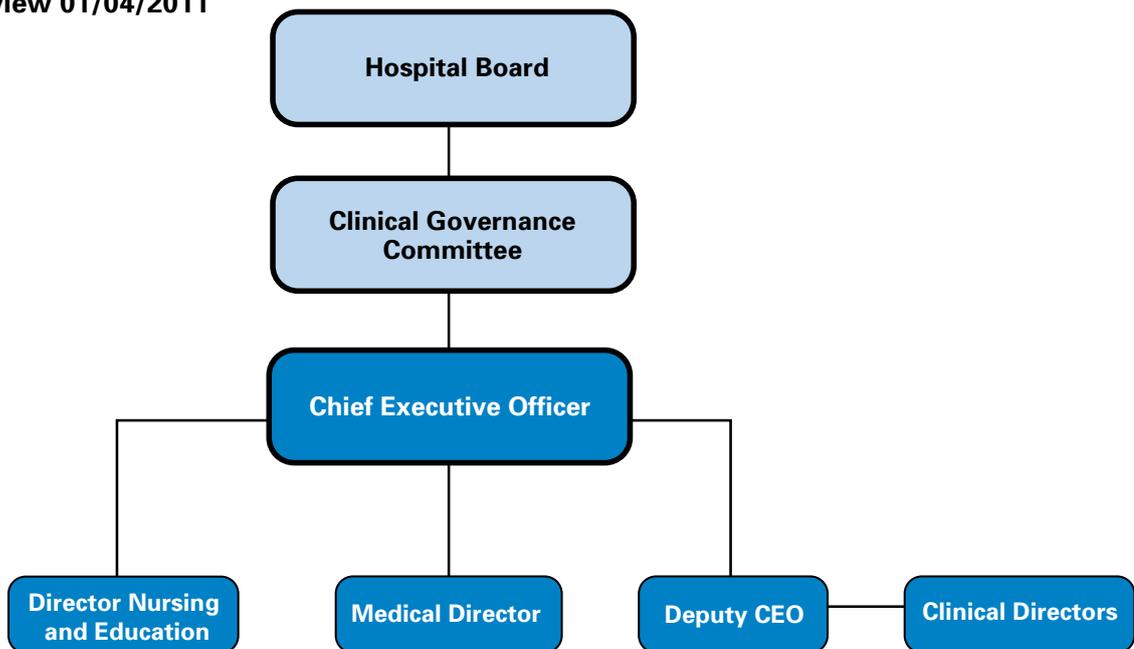
efficacy, sustainability and the potential risk of such an arrangement. The HSE was aware of this risk through members of the Executive Committee meeting with representatives of the HSE at the monthly performance review meetings.

The Hospital provided a separate diagram to depict the clinical governance structures (Figure 10). This suggested that reporting on clinical governance was through the Chief Executive to the Clinical Governance Committee to the Hospital Board. However, as already described in 9.4.3, the Clinical Governance Committee was conflicted because of the number of Executive members and the lack of role clarity.

Figure 10: Clinical Governance Structure at Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH)

AMNCH Clinical Governance

Overview 01/04/2011



The Authority found this clinical governance organisational structure was not aligned to the accountability arrangements described by the HSE, congruent with the Hospital or Board governance arrangements or individual post holder's job descriptions⁽⁵⁷⁾. This incongruity was evident from documents reviewed by the Investigation Team and described at interviews.

10.2.2 Executive role and responsibilities

Notwithstanding the fact that the Charter does not recognise the office or role of a Chief Executive, such a post holder has professional accountability to exercise their function in line with the aligned responsibility of the post. Prior to the commencement of the investigation, the executive management arrangements at the Hospital had, over the last 3 years, gone through a number of significant changes. Over that period, there had been five members of staff acting in the role of Chief Executive. The Authority explored the executive governance arrangements with members of the Hospital Board who reported that the Chief Executive's role and functions in the Hospital were described through the aligned job description. At the time of the commencement of the investigation, neither the Acting Chief Executive nor acting Deputy Chief Executive Officer (who was also the Director of Nursing) had formal job descriptions. In addition, there were no performance objectives in place for the post of Chief Executive or records of formal performance review meetings for the post holder with the Chairperson of the Hospital Board.

In Ireland, the role of a Clinical Director is a relatively new role with additional funding provided by the HSE to establish such positions. The position was introduced in 2008 with a consultant contract having an initial 2 year contract for the role of Clinical Director.⁽⁵⁸⁾ The role description states that the post holder reports directly to the Chief Executive of the non-statutory hospitals and is a member of the Senior Management Team. The post is part-time with a remuneration of €46,000 per annum (Revised from €50,000 with effect from 1 January 2010).⁽⁵⁹⁾ It was envisaged that Clinical Directors would be facilitated to fulfil the responsibilities of their role through a number of support structures which included locum cover, secretarial assistance and management support. It was expected that the post holder would have delegated responsibility, accountability and the necessary authority for the deployment, management and performance of clinical resources, patient safety and quality of care. Also, in conjunction with the Chief Executive, the Clinical Director should ensure that the strategic direction taken by the healthcare organisation is informed by, and takes into account of, all the organisations corporate and clinical risks. This additional role, and the related responsibility and accountability, is recompensed through funding from the HSE.⁽⁶⁷⁾

The Hospital had formal HSE funding for one Clinical Director's position and this post had been allocated initially to the Clinical Director for Medicine. At the time of commencement of the investigation, the funding was allocated to the post in the Peri-operative Directorate. In addition, the organisational structure described three other specific clinical directorates which were medicine, diagnostics and paediatrics.

At the commencement the investigation, three of the four clinical director positions were permanently filled, with a consultant physician temporarily acting as the Clinical Director for Medicine. These roles reported to the acting Deputy Chief Executive. The Clinical Directors had received limited development for the role.

There were ambiguous lines of reporting with the role of the Medical Director not clearly understood.

A member of the consultant staff had been appointed to the post of Medical Director in 2009 by the Board following an internal competitive process. This was a part-time post of 12 hours per week with a substantial additional remuneration for the post. The accompanying job description described that the post was responsible for providing overall leadership of the medical workforce and maintaining standards of medical care at the Hospital. The position was outlined as a senior executive post and a key member of the Senior Management Team. The role, as described in 2009, was accountable to the Chief Executive and responsible for, among other things, carrying joint accountability with the Director of Nursing for the implementation of the Hospital's Clinical Governance programme, monitoring of standards of care and benchmarking against accepted standards, facilitating the development of the clinical directorate structure and advising the Chief Executive on serious complaint issues. However, this role description was not revisited by the Board in 2010 while the post holder also held the post of designate Chief Executive.

At the time of commencement of the investigation, the Authority found that the Medical Director was not a member of the Executive Management Committee. The Authority was unable to establish the exact roles and responsibilities delegated by the acting Chief Executive to the Medical Director, in particular those in relation to the quality and safety function. The Authority found that the acting Chief Executive understood that the Medical Director had delegated responsibility for quality and safety at the Hospital. However, the Medical Director did not accept that this role and responsibility was within their specific job remit. This lack of clarity had also been discussed at the Board Meetings as outlined in Section 9.8.1. There were no performance objectives in place for the post of Medical Director or records of formal performance review meetings between the post holder and the acting Chief Executive.

The Director of Nursing, at the time of the commencement of the investigation, had also taken on some additional operational aspects of the role of Deputy Chief Executive although had no formal job description for that role. The role of the Director of Nursing was described as being accountable for the quality and safety of nursing care provided to patients.

In 2010, the Hospital had experienced extensive external scrutiny in relation to the quality and safety of care provided to patients. However, at the time of the commencement of the investigation, the Authority found that there was ambiguity about the overall executive accountability, responsibility and authority for quality and safety. The role descriptions and responsibilities did not reflect the significant challenges experienced or the changes in the executive governance arrangements that had occurred in 2010 and 2011. In addition, the differentiated roles of Medical Director and lead Clinical Director were not clearly articulated or understood. There

was also a lack of clarity about the overlap of other operational roles in particular where additional responsibilities had been subsumed by some post holders in the absence of updated role descriptions and clear communication of these changes.

10.2.3 Executive Committee

At the time of the investigation, and prior to the commencement of the newly appointed Chief Executive Officer in August 2011, the Terms of Reference for the Executive Committee meetings included financial management and forecasting, executing the decisions of the Board and ensuring that quality and safety was at the forefront of service planning and delivery. The Authority reviewed the minutes of the Executive Committee Meetings (11 January to 18 July 2011). The Authority was not satisfied that the configuration or documented functioning of the Executive Committee was structured to effectively deal with the accountability and responsibility aligned to their executive management function, for example:

- the Executive Committee meetings were poorly attended. There were multiple meetings with no Clinical Director recorded as being present. The Authority found that the post of the Clinical Director (Medicine) was vacant for this period. However, there were other Clinical Directors in post
- there were no meetings between 18 April and 16 May 2011
- the general tenor of the minutes reviewed was dominated by the deteriorating financial position
- limited documented reference to patient safety, risk and quality issues
- the agenda or subsequent minutes did not differentiate between items for information, items for approval and items for discussion
- action sheets were included with each set of minutes with an identified action lead. However, these were observed to be stand alone action sheets and the minutes of the follow-up meeting did not provide a clear update on the status of these actions or decisions taken
- the minutes document that the ED was discussed in terms of activity, catchment resources and costs, with no discussion on the quality and safety of care and services provided to patients.

Specifically, in relation to the Authority's concerns about the risks to the health and welfare of patients being accommodated in the corridor adjacent to the ED:

- there was no information provided to suggest that the Authority's concerns about the risks to the safety and welfare of patients were discussed or that any mitigating actions were considered until 16 May 2011
- the minutes of 16 May 2011 referred to a request from the Authority relating to the circumstances surrounding the death of an admitted patient who had been on the corridor adjacent to the ED whilst waiting to be transferred to an inpatient facility in the Hospital

- the minutes of Executive Committee meetings do not refer to the multiple correspondences from the Authority that point to a delay in responding and concerns relating to this.

10.2.4 Executive monitoring of the quality and safety of care to patients

The members of the Executive Committee interviewed stated the quality and safety of the care provided to patients had always been a priority. Minutes of the Executive Committee meetings did not suggest that any debate took place or that patient safety was discussed as a matter of course.

However, in relation to patients being cared for in the corridor adjacent to the ED, the Authority found the Hospital implemented a revised escalation policy which was aligned to the HSE Full Capacity Protocol.⁽⁶⁰⁾ This involved a process to facilitate the transfer of patients from the ED to inpatient wards following a decision to admit which is triggered by a number of agreed benchmarks which include ED bed occupancy, ED waiting time breaches, the number of patients awaiting assessment, treatment or for an inpatient bed.

Members of the Executive Committee reported that the implementation of the Hospital's revised escalation policy had been delayed at the request of the HSE while national industrial relations issues were being resolved. The acting Chief Executive corresponded with the HSE in August 2010 requesting the conclusion of the Full Capacity Protocol and, in October 2010, requested that the Full Capacity Protocol be included in the Croke Park Agreement. It is noted that, in response to safety concerns, the acting Chief Executive initiated the escalation policy in advance of the national agreement and against a backdrop of local industrial relations issues. In addition, the acting Chief Executive also commenced an initiative in April 2011 to reduce the threshold for the number of patients being cared for in the corridor adjacent to the ED from 60 to 15 over a period of time.

There was no information in the minutes that reported trends of patient feedback, clinical incidents, adverse events or the prevention and control of healthcare associated infections being presented to the Committee. The Authority was advised by members of the Executive Management Team that there was no overall integrated executive approach to assuring the quality and safety of care provided or to the management of risk. However, interviewees stated that the Clinical Governance Committee had oversight with a number of other arrangements and Committees where the quality and safety of care and risks were considered. These included:

- **Clinical Directorates**

The Authority reviewed the meeting schedule for 2010 and 2011 for the Peri-operative, Medical and Diagnostic Directorates. At interview it was stated that in addition to the Medical Directorate, there was also the Division of Medicine with a Chairperson which held separate meetings at which clinical professional issues were discussed. There were also a number of identified

lead clinicians, chairing their clinical specialty meetings within the Peri-operative, Medicine and Diagnostics Directorates.

The minutes of the Diagnostic Directorate's meetings indicate that quality and safety metrics, patient complaints, patient safety incidents and adverse events were considered. The minutes of the meetings of the other Directorates indicated that patient safety was not discussed as a matter of course. This may have been, in part, due to the early stage of evolution, retirements and the changing governance arrangements.

It was reported at interviews that the Directorates were in an early stage of development and there were a number of challenges including a lack of dedicated administrative, business and clinical support arrangements in place. Following the appointment of the new Chief Executive, it was reported at interview that the post holder intended to address these deficits and strengthen the directorate structures through a planned organisational restructure with the additional allocation of directorate business support.

■ **Clinical Audit**

Service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which learning takes place and excellence in clinical care is provided and will flourish. Clinical audit supports and directs continuous quality improvement and is an important method that any individual, clinical team and healthcare organisation should use to understand and assure the quality of care it provides to patients.

The Hospital's Clinical Audit Committee was described as a subcommittee of the Clinical Governance Committee. The Terms of Reference indicated that the Committee met quarterly. The Medical Director was the Chairperson with a membership of seven staff representing three of the clinical directorates, nursing services, allied health professionals and a clinical audit manager. In addition, the Authority was advised that the Medical Director had resigned from the post in September 2011.

At the commencement of the investigation, the Hospital had a draft Clinical Audit Strategy and Handbook (2011 – 2013). The status of these documents was unclear. It was reported at interview that the Hospital had not successfully appointed a Director of Quality, Safety and Risk at the time of the investigation. The Authority was advised that, in the interim, the operational responsibilities were being shared between the Chief Executive and Deputy Chief Executive.

However, the Authority was provided with examples of Hospital specific clinical audit activity which included, for example, a wide range of clinical practice audits from critical care, endocrinology, pharmacy, vascular and upper gastrointestinal surgery, infection control, wound management,

cardiology, orthopaedics, nephrology, allied health professionals, laboratory medicine and nursing services. A selection of the 2011 clinical audits, findings and actions, were presented at the March 2011 Hospital annual clinical audit day. For example, the community intravenous service audit demonstrated that treatment in the community was very effective with only 3.2% hospital readmission rates and a high patient satisfaction rate. It was said that this had a significant impact on acute bed-day savings which have resulted in a saving of €457,300 for the Hospital.

Clinicians reported that each clinical specialty held monthly mortality and morbidity meetings where patient complications and deaths were reviewed by the clinicians. However, there were no records available of these meetings.

In 2010, a suite of nursing sensitive outcome measurements, the Nursing Instrument for Quality Assurance (NIQA), were developed. These were audited every two months across 12 hospital wards. The aim of these audits was to support nurses in clinical practice to measure and define the quality of their care delivery in eight key areas of practice and to identify risks to patient outcomes and safety. A ninth patient experience indicator was also developed. It was reported at interview, that any ward area audited at the 'Red' level of non compliance was required to put a quality improvement action plan in place. Documentation provided outlined the bi-monthly indicator compliance results from November 2010 to July 2011 and indicated the overall improvement in compliance with the Hospital's best practice standards across the 12 wards.

■ Risk Management

Risk management is the systematic identification, evaluation, management and monitoring of risk. Providers must ensure and demonstrate that every effort is made to avoid harm to patients by providing safe systems of care that minimise risks.

The Hospital had an established Forum for Adverse Incident Review (FAIR) which was chaired by the Chief Executive or the Deputy Chief Executive. This Forum reported to the Clinical Governance Committee. The Terms of Reference of the FAIR pertained to continually improving the safety and quality of care to patients and supporting staff in their practice by ensuring lessons are learnt from the reporting and analysis of incidents/near misses, patient complaints, claims reviews and Coroners' Inquests.

The FAIR met every four to six weeks, with extraordinary meetings held in the event of a serious incident. Core members of this Committee consisted of the Deputy Chief Executive, Medical Director, Director of Nursing, Chairperson of the Medical Board, Risk Manager, Assistant Directors of Nursing from the Medical, Peri-operative and Children's Directorates, Clinical Director for Diagnostics, with the Patient Advocacy Officer and Drug Safety Coordinator in attendance.

It was reported that there was no formal mechanism in place for the feedback from the FAIR meetings. However, members of the FAIR had the responsibility to report back to their peer groups for learning to be shared. Staff educational sessions were facilitated by the Risk Management Office updating staff on learning from anonymised incidents. All reviews and recommendations were logged on the Hospital's corrective action register and it was reported that formal meetings were held every six weeks to ensure that recommendations from learning were assigned to staff for implementation.

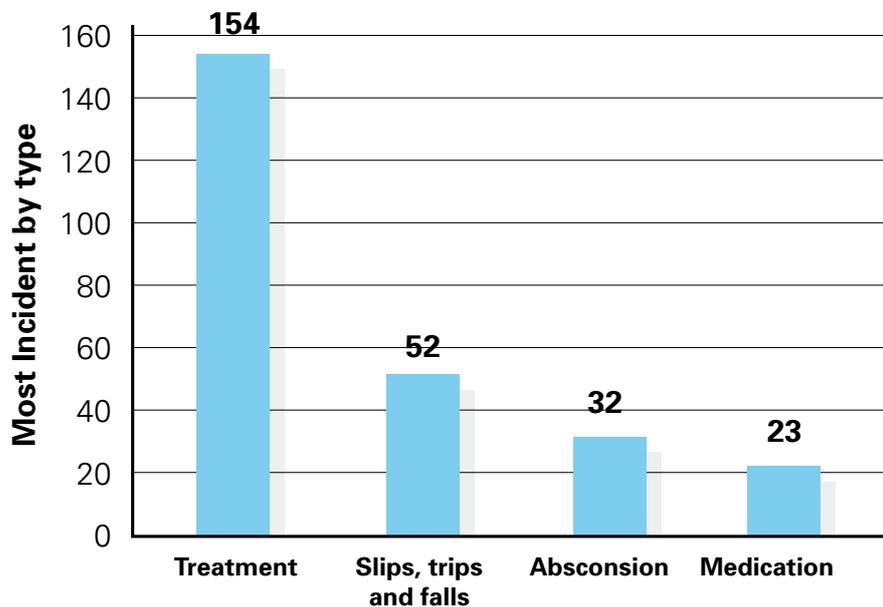
It was found at interview, that the Risk Manager facilitated and supported staff in the use of the risk management process but did not have accountability for the management of risk. The Hospital organisational chart aligns the governance of risk management to the Director of Quality and Risk. However, as mentioned previously, this post was vacant at the commencement of the Investigation. At interview it was stated that the Risk Manager was, at that time, reporting to the Chief Executive.

Incident management, including the reporting and analysis of incidents and near misses, was managed in line with the policy for the Management, Reporting and Analysis of an Incident, Serious Untoward Incident and Near Misses at the Hospital, through the Risk Management Department. In accordance with the policy, reported incidents graded red and/or of concern and monthly trend analysis reports were submitted to the FAIR committee for review. The Authority reviewed the FAIR minutes from February to July 2011. These suggested that the Committee's decisions or recommendations in relation to the monthly incident trend reports were not consistently recorded.

All reported incidents were entered on to the STARSweb system which is the National Incident Reporting Database.⁽⁶¹⁾ In the first quarter of 2011 (January to March) an overall total of 586 incidents were reported at the Hospital. The most frequent incidents reported related to slips, trips and falls (51%, n=300) and treatment (18%, n=107).

Through documentation review, a total of 331 clinical incidents were reported in relation to the emergency department (ED) (n=304) and the corridor adjacent to the ED (n=27) in 2010. Figure 11 illustrates the most frequent type of clinical incidents reported in the ED and the Corridor adjacent to the ED.

Figure 11: Most frequent type of incidents reported in the Emergency Department and corridor adjacent to the ED – 2010



The FAIR had in place a corrective actions register that included recommendations from Coroner's reports, internal and external reviews. However, the Authority found that the information, held within this register, was not consistently included in the hospital's risk register.

At interviews, it was found that FAIR linked with the Clinical Governance Committee of the Hospital Board through the provision of a verbal synopsis of trends and issues relating to incidents.

In relation to the specific patient safety issues concerning the ED and acute admission patients, in March 2011, concerns about the safety of care to patients in the corridor adjacent to the ED and in particular the death of a patient were brought to the attention of the acting Chief Executive, the Medical Director and the Chairperson of the Board by the Emergency Medicine Consultants. At that time, the acting Chief Executive requested an independent internal group to carry out a review of this incident and requested that the report, with recommendations, be presented to the FAIR committee. The report was completed on 7 June 2011.

As previously discussed, the Authority was informed of this incident and that a review was in progress in April 2011. At this time, the Authority wrote to the acting Chief Executive requesting a copy of the incident review report and assurances regarding the accountability arrangements for the care of patients on the ED corridor, an ED plan to mitigate these risks currently and for the medium and longer term, as well as a briefing of how the Board was updated on these risks through the Hospital's clinical governance arrangements.

A copy of the incident review report was not received by the Authority until 20 June 2011. The Authority found that this review did not effectively address the patient safety issues and the requested assurances were not provided nor was there any information provided as to how the Board was advised of serious risks. An overview of the Authority's engagement with the Hospital is discussed in the Background section of this Report.

However, as part of the Investigation Team document request, the Hospital subsequently submitted as evidence a more detailed clinical governance review of the corridor adjacent to the ED which had been commissioned by the Board through the FAIR in June 2011.

The Authority found that, although the Hospital had a number of systems and processes in place to manage risk, these were at an early stage of evolution. The focus was on the management of individual adverse incidents rather than looking at incidents as indicators of potential risks to current and future service delivery.

However, the Hospital should have effective risk management processes in place which balance the review of individual incidents, ensuring that they are effectively managed and any issues addressed, with the importance of drawing wider conclusions and learning about risks resulting from the ongoing monitoring of trends in patient safety events. Through interview and documentation review, it was noted that there was a gap in relation to the arrangements in place for the executive oversight of quality and safety between the management of individual incidents and overall risk management.

■ Risk Register

The policy of the HSE was "to operate an integrated process for the management of risk".⁽⁶²⁾ This includes the development of a risk register to facilitate the identification of and mitigating action to deal with identified risks. Regionally, each local hospital's risk register is aggregated and reported nationally to the HSE to inform the national allocation of resources and the design of improvement plans to manage risk.

At the commencement of the investigation, the Hospital's Risk Register Task Force was in the process of developing a hospital-wide risk register, with each department submitting their top 5 risks. Through documentation review, the FAIR group identified the overall hospital top 5 FAIR risks for inclusion in the risk register as falls, patient identification (including misfiling of documentation), failure to recognise and/or escalate and act on a sick patient, staffing levels and workload and delay in diagnosis or misdiagnosis.

In June 2010, the external consultants who had carried out a review of the governance arrangements were asked to assist in the identification of risks and quality issues at the Hospital. At that time, these external consultants

identified the top risks in the ED and the corridor adjacent to the ED. Those risks included care of non-ED patients within the ED, health and safety issues, capacity, medical records security issues, patient safety, privacy and dignity and availability of isolation rooms. In particular, the use of the corridors within and adjacent to the ED to board patients while awaiting further assessment/treatment or admission to an inpatient bed were identified as a risk.

Documents provided to the Authority demonstrated that in September 2010, the ED staff validated these risks and identified interim control measures as well as identifying that the use of the corridor adjacent to the ED should be ended immediately.

However, until the time of the unannounced inspection by the Investigation Team on 24 August 2011, the corridor continued to be used to accommodate patients.

■ **Complaints Management**

A responsive complaints and concerns management system provides an essential pathway for patients and their relatives to question and understand what has happened to them. Engaging with patients in the complaints management process to ensure any resolution is satisfactory from both a service provider and patient perspective is imperative. In addition, it promotes accountability, affords the service providers with an opportunity to learn how the system of care could be improved and make decisions to implement change where required.

At the Hospital, complaints were managed in line with the Patient Complaints Policy through the Patient Advocacy Department, with the Patient Advocacy Officer acting in a dual role as the Complaints Officer. It was reported that there was a complaints database in place within the Hospital to record complaints which also facilitated the production of reports. During the patient experience interviews, a number of patients made particular reference to the helpfulness of the complaints team when managing their complaints, although it was their perception that the team were not fully supported by the Hospital. This was explored at interview with the Patient Advocacy Officer, who reported being very supported in her role by senior management.

Through the documentation review of the Hospital's Inpatient Experience Survey 2010⁽¹¹⁾, it appeared to the Authority that 66% (n=170) of respondents were not aware of the complaints procedure within the Hospital.

Respondents were asked if they had a complaint to identify who they discussed their complaint with. Of those who responded (n=103), 41% chose not to discuss their complaint with a member of the healthcare team and identified the main reasons for this as staff not available, were too busy or did not have the opportunity. The majority of those respondents who did raise their complaint spoke to a nurse or the nurse in charge.

Through the documentation review, it appeared to the Authority that the Hospital's organisational chart aligns the governance of Patient Advocacy to the Director of Quality and Risk. However, as mentioned previously this post was vacant. At interview, it was reported that all complaints were reviewed weekly with the acting Deputy Chief Executive and complaint trend analysis reports are submitted to the FAIR. However, the Authority reviewed the minutes of the FAIR and noted that the complaints update was deferred over three consecutive meetings. It was also indicated that no formal reports were submitted to the Patient Forum for review.

The Authority found that, as with Risk Management, there were limited arrangements in place for the executive oversight of complaints and the implications for overall quality and safety.

10.3 Corporate relationships with stakeholders

10.3.1 Patients

Person-centred care and support places service users at the centre of all that the service does. This can be done through a variety of different means including by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Good patient experiences are an important outcome for all healthcare services. The service actively engages with patients, as part of their local community, to ensure that their current and anticipated needs and preferences are taken into account when planning and designing services. This includes stakeholder involvement and ongoing monitoring and evaluation of service provision from the patients' perspective. Learning from complaints, concerns, claims and compliments plays an important role in promoting improvements in the safety and quality of patient care.^(5,63)

Absence of readily available information makes it unnecessarily difficult for people who want to resolve issues and who might not wish to formally complain about their experience. A number of patients who were interviewed stated that there was no information provided in the ED or elsewhere in the Hospital about advocacy services. The Authority has previously made recommendations about the availability of advocacy services in its *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Services Executive at the Mid-Western Regional Hospital Ennis*.⁽⁷⁾

In September 2010, the Hospital established a Patient Forum which reported to the Hospital Board. Membership included senior hospital Executives, a Hospital Board representative and public members nominated by local community groups, with one elected as the chairperson. The Forum met twice yearly and its remit was to provide recommendations to the Board in relation to the quality of current

and planned services. However, there were no formal arrangements in place for the Board to consider the Forum's feedback. In addition, the Authority found that the Forum update was not included in the Board minutes.

Public representatives on the Forum were very positive about their engagement with the Hospital and reported that all issues they identified were taken seriously and addressed. For example, Forum members championed the development of the GP out-of-hours service. It was noted that issues considered by the Forum were identified through the community groups.

Whilst the benefits of the Forum were reported, it was in the development phase and should be reviewed and evaluated on an ongoing basis to ensure it is fit for purpose.

10.3.2 General Practitioners

Integrating care for patients between primary and secondary care providers is an essential element of safe and quality care. Hospitals should have in place arrangements to consider the views of all stakeholders. In particular general practitioners need to be consulted so that their views inform the clear and transparent decision-making processes, including referral pathways, which need to be in place to facilitate a patient's timely and appropriate access to the healthcare services provided by the Hospital.^(5,43)

The Hospital had established a GP/Hospital Liaison Committee in 2004 with Terms of Reference. These included the development of cooperative working arrangements between GPs referring patients to the Hospital and the Hospital consultants and the identification, prioritisation and approval of strategic and operational initiatives which enhance coordination between the Hospital and primary care services to ensure better access to services and outcomes for patients.

The Terms of Reference also included that the Committee:

- was to meet monthly and the membership included the Chief Executive and/or the Medical Director, 3 GP representatives and pertinent hospital representatives, including clinical directors, ED consultants, GP liaison nurse in ED and the primary care development team
- reported to the Hospital Board and to the Regional Director of the HSE through the Chief Executive.

At interviews, it was stated that it took approximately two years to initiate the Committee and that there had been a number of challenges to the Committee's success. These included inconsistent attendances of the Hospital's senior Executive and consultant staff.

At interviews it was said that GP representatives had stopped attending the Committee meetings for a period of time as issues important to them were not

being addressed by the Hospital. It was stated that GPs, for an extended time, had raised concerns about excessive delays for patients waiting to access outpatient services, in particular radiology services. However, their concerns were not considered as patient safety incidents and there was no process for these concerns to be escalated to the Executive Management Team or the Board for response and action. There was no formal process to advise GPs of the services provided by the Hospital or the waiting times for these services.

The Authority concluded that the GP Liaison Committee, as it was constituted, was not an effective mechanism for integrating primary and secondary care for the benefits of patients.

10.3.3 Health Service Executive

At the time of the investigation, the HSE was the national organisation with the statutory responsibility for delivering health and personal social services. In 2004, the Health Act provided for the reform of the management structures in the Health Service, by providing for the establishment of a single national organisation with responsibility for the delivery of health and personal social services in Ireland.⁽⁴⁷⁾

The HSE entered into an arrangement with the Hospital which allowed it to provide services on behalf of the HSE. This Service Arrangement, pursuant to Section 38 of the Health Act 2004⁽⁴⁸⁾, forms the basis of the relationship between the HSE and the Hospital. The HSE, under this arrangement, remained accountable for the provision of the health services but funded the Hospital to the amount of €189 million in 2010, to provide services on its behalf.

From the evidence available to the Authority, it would appear that neither the Executive Management Team nor the Board used the Section 38 Service Arrangement as a framework for decision making in relation to the provision of services provided and funded by the HSE. This is further discussed in Chapter 11.

The Hospital Board did not appear to understand that the role of non-statutory hospitals changed with the advent of the Health Act 2004. The investigation found that there was a lack of clear understanding by some members of the Hospital Board of where the HSE's responsibilities ended and where the Board and the Hospital's responsibility for operational and clinical performance started. Some of those interviewed suggested that not all of the Board fully understood its relationship with the HSE, with some Board Members questioning the legitimacy of the HSE's interest in the Hospital's service activity and efficiency. The situation described by some interviewees was that the Hospital "felt under siege by the HSE". In particular, the decisions to transfer the cancer services and the location of the National Children's Hospital site led to a view that the HSE was unduly trying to influence its strategic direction. Many of those interviewed perceived that the HSE was not adequately funding the service being provided. The Authority found that the role of the Hospital as a service provider on behalf of the HSE was not fully understood. This was confused by the dual reporting to the Board and HSE and the non-alignment of the Hospital's preference for the provision of some services with the HSE's requirements and intent.

The Authority found examples of uncertain and confused responsibilities and unclear accountabilities characterising the relationship between the Hospital and the HSE. This will be further discussed in Chapter 11.

10.4 Conclusions

10.4.1 Executive Management

A number of the findings in relation to the executive management of the Hospital have been covered in section 9. In addition to these findings, the Authority found that although the Hospital had developed a number of operational strategies, which included quality and safety, risk management and clinical audit, these strategies were at various stages of development and implementation. Notwithstanding this, the Authority concluded that the key elements which are necessary to ensure the successful implementation of these strategies were lacking.

The turnover of senior executives in the Hospital, and the ongoing 'acting status' of individuals in key positions, created challenges in leadership, management, stability, decision making, confidence and authority. This had the potential to impact on the ability to effectively address the quality, safety and financial challenges that the Hospital faced which included the challenges of the governance structures, Board functionality and general governance arrangements in the Hospital.

The Authority found that:

- there was ambiguity as to who had overall executive accountability for the quality and safety of the services delivered
- the required formalised integrated corporate and clinical governance arrangements with clear lines of accountability at individual, team and service levels were not in place
- the Hospital did not adequately plan or control the scope and/or expansion of the clinical services they provided in order to ensure that they had the supporting diagnostic and therapeutic services to support the provision of these services
- not all of the workforce were aware of their responsibilities and accountabilities
- robust arrangements were not fully in place for the planning, controlling, managing and organising of the service to achieve the best outcomes for patients in the short-, medium- and long-term. However, the Hospital did have a number of policies and programmes which were designed to facilitate an improvement in OPD turnaround, bed management practices, patient discharge planning arrangements and the management of admitted patient waiting for an inpatient bed whilst in the ED

- the effective management arrangements that were needed to facilitate the delivery of high quality, safe and reliable care and support by allocating the necessary resources through informed decisions and actions were not in place
- there was limited alignment of local, regional and national accountability for planning and delivering services.

The Authority found a lack of an effective corporate and clinical governance approach within the Executive Management arrangements.

10.4.2 The national perspective

From a national perspective, it is imperative that the capacity and capability of leaders and senior managers in healthcare organisations, and the wider health system, have the core competencies and capabilities to successfully lead, manage and execute the challenges and requirements of running a healthcare organisation, with a strong culture of openness, learning and continuous improvement. The chief executive, executive directors and other senior managers, should be recruited and appointed with these competencies and effectively supported, developed and performance managed to ensure that they are capable of delivering in this role as both individuals and as members of a high performing management team.

The provision of high quality and safe health and social care services is complex and increasingly pressured with constrained resources. However, the public needs to have confidence that when they need to access healthcare, the experience and care that they receive is of a high quality and safe, 24 hours a day, seven days a week. In order to deliver this consistently and reliably, the leaders and managers of today and the future must ensure that there are effective governance and managerial arrangements in place, with a focus on high performance and delivery, within the resources available.

In order to ensure that this is in place, all boards should establish a clear scheme of delegation of accountability and responsibility to the chief executive and, through the chief executive, to other designated executive directors. All chief executives must have annually agreed objectives with the chairperson and the board, that accurately reflect the realm of their accountability, responsibility and authority and be subject to effective performance management and development reviews to assess their performance. Where there are issues of poor performance, the chief executive should be supported and developed and where these issues persist, action should be taken accordingly within an established process.

The same process should exist for the setting of objectives and performance management and development of executive directors by the chief executive and similarly, through an established process of delegation throughout the organisation.

Given the substantial amount of public money that is entrusted to service providers that are in receipt of State funds, there should be a more robust mechanism in place to oversee the recruitment, appointment, performance and replacement of the chief executive of these service providers on behalf of the State. Similarly, there should be greater involvement in the performance management of the chief executive of these organisations by the State, specifically for the purpose of holding the chief executive accountable for the performance and delivery of the commissioned service. This should be through a clear line management relationship of all hospital (in the first instance) chief executives firstly to the chairperson as their line manager and, in addition, to a nationally designated post-holder (this may be, for example, the Director of Hospital Care of the new HSE structure, or equivalent).

The Authority would consider the requirement to invest in building stronger and more effective leadership and management capacity and capability throughout the health and social care system as being a fundamental requirement, and a significant success-determining factor, for driving sustainable improvements in our health system and the implementation of effective change both now and in the future. This imperative includes investing in clinicians and clinical teams, senior managers and directors, chairpersons and board members, commissioners of services and policy-makers.

In order to better support the capability and development of existing leaders and managers, the current programmes for leadership and management development provided by the State, and/or academic institutions and Postgraduate Training Colleges, should be reviewed with the view to mobilising commitment nationally in order to consider a mixed faculty of clinicians and managers to provide mandatory local development and training for such individuals in accordance with a curriculum that includes effective governance, management, managing change, safety, quality, modernisation tools and use of resources.

To invest in our leaders and managers of the future, there should be clear managerial career progression pathways established, for both non-clinical and clinical leaders and managers, to ensure that individuals receive the appropriate vocational training and development and human factor skills required for the role.

Recommendations – Executive Management

- 1.** All service providers must have clear accountability and performance management arrangements in place to achieve the delivery of high quality, safe and reliable healthcare
- 2.** The Chief Executive, and the Executive Management Team, should ensure that the implementation of the organisation's strategy, and the operational running of the business, is specifically and effectively aligned to the delivery of good quality and safe care within the available resources. The relationships with stakeholders, engagement with the public, organisational structure, delegated roles and responsibilities, governance fora, output and outcome measures and the business content of meetings should all reflect this purpose.
- 3.** The Chief Executive must be accountable for ensuring that there is an effective process in place to annually agree objectives that reflect the delegated accountabilities and responsibilities for executive directors, and all staff within the organisation in order to deliver high quality safe services to patients.
- 4.** The Chief Executive must ensure that there is an effective performance management and development system in place to support, develop and manage the performance of the executive directors and all staff within the organisation. Where there are issues of poor performance, the member of staff should be supported, developed and where these issues persist, action should be taken accordingly and within an agreed process.
- 5.** As part of the establishment of 'Hospital Groups/Networks' from the current State funded hospitals, competent high performing chief executives and executive directors (including director of finance, medical/lead clinical director and director of nursing) with clear delegated accountability should be appointed.
- 6.** The appointment of a chief executive of a service provider in receipt of State funds should be overseen by the board with the appropriate degree of involvement from the director of hospital care (or equivalent designated individual).
- 7.** The chief executives of all hospitals (in the first instance) in receipt of State funds, should be line managed by the chairperson as their direct line manager and, in addition, by a nationally designated post-holder for the purpose of holding the chief executive accountable for the performance and delivery of the commissioned service (this may be, for example, the Director of Hospital Care of the new HSE structure, or equivalent).
- 8.** There should be a clear career progression for leaders and managers – both in non-clinical and clinical areas, to ensure that individuals receive the appropriate vocational training and development and human factor skills required for a senior management role.

11 Planning, Accountability and Oversight Arrangements

This section of the Report will explore the HSE's regional and national arrangements to plan, and govern the provision of safe, quality services in the Hospital and how this impacted on the Hospital.

11.1 Background

The Hospital is a public non-statutory hospital which opened in June 1998 following the amalgamation of three federated hospitals from the inner city of Dublin. Historically, non-statutory (federated and voluntary) hospitals developed individual annual service plan proposals and submitted these directly to the Department of Health who as the "Vote-holder", in return, allocated funding in line with a service plan.⁽⁶⁴⁾ This funding relied upon a model of incremental budget increases and was related to provider supply and practice patterns that may have been appropriate at the time. This individual provider funding had the potential to lead to individual provider-focused, and clinical specialty influenced, development of services that could overshadow the common good of population and patient needs. The Health Act 2004⁽⁴⁷⁾ provided for the reform of the structures in the health service, by providing for the establishment of a single national organisation with responsibility for the planning and delivery of health and personal social services in Ireland, which was the HSE.

In accordance with the Health Act 2004⁽⁴⁷⁾, the HSE may enter into arrangements/agreements with non-statutory provider organisations to deliver services on its behalf under Section 38⁽⁴⁸⁾ of that Health Act. However, the HSE remains accountable to the Oireachtas for all expenditure on health and personal social services incurred from public funds and to use the resources it is allocated in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public. This includes monies subsequently allocated to non-statutory organisations to provide services.

11.2 The strategy and model for the delivery of the health service

The HSE is a centralised national organisation responsible for the planning and delivery of health and personal social services in Ireland. The HSE Board and executive management team defined and agreed the Service Delivery Model. At the time of the investigation, the HSE's operational line for the delivery of this service model was through an Integrated Services Directorate structure which included four regional directorates, one of which was Dublin Mid Leinster. This Integrated Service Area (ISA) model was based on all services being population focused and having effective integrating arrangements in place.

The HSE provided the Authority with a formal delegation of functions between the National Director of Integrated Services – Performance and Financial Management to the Regional Director of Operations and from the Regional Director of Operations to the ISA Manager, in relation to service delivery and performance management within their designated areas.

In addition, the HSE had a number of national arrangements in place in relation to risk management, including the National Incident Management Team, which supports providers in the reporting, investigating and response to adverse incidents. This team had been involved in the review of serious incidents at the Hospital.

11.2.1 Integrated Service Areas

The HSE, based on national and international practice, identified ISAs in order to integrate the delivery, management and funding of secondary care, primary care and continuing care services for a shared population. Each of the identified ISAs contained a hospital or a number of hospitals that provided for all of the secondary care acute hospital needs for that community (not including specialist tertiary acute hospital services). However, the Authority found that the HSE agreed the ISAs for Dublin and the Greater Dublin areas in the absence of key decisions relating to the configuration of services. These included knowledge of the capacity of some hospitals, no clearly defined scope of services that could be provided safely by each hospital, uncertainty in relation to academic alliances and agreement about patients' eligibility to access services outside their catchment area.

In addition, there was no national plan defining what tertiary and quaternary specialist health services should be provided at which facility across the country, or contractually by other jurisdictions, based on informed factors including population need, forecasted activity and geographical distribution. Information provided to the Authority showed that the involvement of ambulance services in the planning of services had not, to-date, been included in the catchment definition.

The ISA for the Dublin and the Greater Dublin areas were managed in two regions, Dublin North East and Dublin Mid Leinster.⁽⁶⁵⁾ Dublin North East has four ISAs

including Cavan/Monaghan, Louth Meath, Dublin Inner City North and Dublin North. Dublin Mid-Leinster was reported as having four ISAs including the Dublin South Central Dublin South/Kildare-West Wicklow, Dublin South East/Wicklow and Midland catchment areas. The Dublin South/Kildare-West Wicklow ISA has a population of 294,013 and includes the Coombe Women and Infant's University Hospital, Naas General Hospital and the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital.⁽⁶⁵⁾

11.2.2 Enforcement of catchment areas

The Authority found that while the HSE communicated internally with its staff in relation to the ISAs and catchment areas, it did not communicate or articulate clearly what and where services were being provided and by which service provider to General Practitioners, patients and other external stakeholders. The Authority found that although there were discussions with the Hospital in relation to catchment, there was no clear information available on decisions in relation to the enforcement of catchment areas in the Dublin Mid Leinster area.

This lack of clarity may have afforded an opportunity for some hospitals, which provided services on behalf of the HSE, to enforce the catchment areas while others did not. There was evidence provided to the Authority that some GPs were advised that catchment areas were defined by the patient's area of residence and not the GP's address and requested to refer their patients to a hospital within that catchment area.

Minutes of meetings between the Hospital and the HSE indicated that the Hospital reported to the HSE that approximately 11-12% of the Hospital's activity was from outside of the defined catchment area and that, in order to meet the agreed service level, they would require enforcement of catchment area. There was no information provided to the Authority as to how the HSE challenged or verified this figure. However, the Hospital had previously signed an agreement with the HSE's predecessor, the Eastern Regional Health Authority (EHRA), to provide vascular surgery services outside the defined catchment area. In addition, it was said that the Hospital also wanted to retain some national services, for example, orthopaedic service for acetabular and pelvic fracture patients, which meant a transfer of patients from outside the catchment area. The Authority was also informed at interviews that the Hospital, in line with their Charter,⁽¹²⁾ wanted to maintain the Hospital as a focus for Protestant participation in the health service and therefore be allowed to treat all Protestant patients, regardless of the catchment area.

11.3 Planning health services in Dublin

The Hospital is one of seven acute hospitals in Dublin providing undifferentiated adult emergency care on a 24 hours a day, 7 days a week (24/7) basis and is one of six hospitals providing 24/7 trauma and orthopaedic services. It also

provides scheduled care including elective orthopaedic services and has a 24/7 children's emergency department. In addition in Dublin, there is also one hospital providing 24/7 cover for ophthalmic emergencies and two additional Emergency Departments providing 24/7 cover for children.

The Government's endorsement of the National Cancer Control Programme⁽⁶⁶⁾, and the HSE's subsequent implementation of this programme, led to a decision that there would be eight designated centres providing cancer services nationally. The Hospital was not identified as a designated cancer centre. In line with the National Cancer Care Programme,⁽⁶⁶⁾ cancer services were moved on a phased basis from the Hospital. In the first instance, the breast cancer service was transferred to St James Hospital and St Vincent's University Hospital. However, despite a clear national decision to transfer cancer services, information was provided to the Authority that a number of the Board, Executive Management Team and clinicians at the Hospital resisted these changes and continued to hold ambitions that other cancer services for patients would not be transferred. At interviews, it was suggested to the Authority that the unplanned consequences for the Hospital following the transfer of cancer services included a reduced ability to attract and retain doctors in training, in particular for surgery and diagnostics, loss of clinical skills and competencies and insufficient surgical consultant staff to provide the necessary twenty-four hour cover for the emergency services.

At the commencement of the investigation, with the exception of the National Clinical Care Programmes, the HSE was unable to provide the Authority with details of a clear single strategic direction for the delivery of unscheduled and scheduled acute healthcare in Dublin. Similarly, there was no blueprint for an acute hospital system, based on population needs, that integrated primary and community care and overall resource availability in the Dublin and Greater Dublin region that considered demand and capacity. This fragmentation may have led to the duplication of some services – both clinical and support services – the absence of other services within the described catchment areas and unclear arrangements to ensure the alignment of local, regional and national accountability for planning and delivering services.

Over a number of years, the HSE had endeavoured to put in place an out-of-hours primary care service. At the time of commencement of the investigation, there was no out-of-hours primary care in the Tallaght area. However, as previously described, this service was commenced in November 2011. In addition, there were no community diagnostic services available. The absence of such services, together with the lack of clearly enforced catchment areas, may have led to the high number of self-referred attendances at the Hospital's ED and the referral to outpatients, either directly or via the ED, to the radiology services both of which contributed to excessive delays for patients in accessing timely care.

11.4 National Service Plan

The HSE National Service Plan (NSP) is the legal basis that underpins the annual funding agreement for the HSE by the Minister for Health.⁽⁶⁷⁾ It sets out how the 'estimate' (budget) allocated to the HSE will be spent in the given year on the type and volume of health and personal social services delivered to the people of Ireland, within the approved employment levels set out by the Government.

The 2011 Dublin Mid Leinster Regional Service Plan⁽⁶⁵⁾ reflected the overall activity levels set out in the NSP for the Dublin Mid Leinster Region and accordingly, Dublin Mid Leinster was allocated €2,716.9 million, a €141.6 million or 4.95% reduction on the 2010 allocation, with a requirement to maintain the levels of services provided in 2010. The Dublin Mid Leinster Service Plan identified the need to develop a clinical network between the Hospital and Naas General Hospital to provide acute services for the population. At the time of the investigation, the development of the clinical network had commenced.

11.5 Arrangements to fund, and governance of service providers

In 2000, responsibility for funding the Dublin Academic Teaching Hospitals (DATHs) was transferred from the Department of Health and Children to the ERHA. The ERHA had a formal structure of commissioners in place who worked with individual voluntary hospitals on the basis of provider agreements/service level agreements. Responsibility for funding the DATHs was transferred from the ERHA to the HSE in 2005, following the enactment of the Health Act 2004.

The HSE, in accordance with the Health Act 2004,⁽⁴⁷⁾ funds the provision of services with non-statutory organisations which is enabled through a Service Level Arrangement (Service Arrangements).⁽⁴⁸⁾

The Authority found that the first Service Arrangements with the Hospital, and other Voluntary Hospitals, were not put in place until 2010. It was stated at interviews with HSE representatives, that this delay was as a result of challenges experienced by the HSE in negotiating these agreements with the non-statutory hospitals in receipt of Section 38 funding. It was suggested that the governance model was evolving and there was still ambiguity about the governance of the provision of health services. This related, in particular, to non-statutory Hospitals which typically have their own Boards in place and who previously were directly accountable to the Department of Health. The Authority was informed that this risk was on the HSE Corporate Risk Register with the mitigating action being the implementation of effective Service Arrangements.

11.5.1 Service Arrangements

The Service Arrangement^(48,49) sets out the framework for the provision of services and details the quality and governance requirements. The Authority found that the Service Arrangement had been operational for the two year period from 1 January 2010 to 31 December 2011 and the schedules detailing the funding allocation and services had been negotiated and renewed annually. This Service Arrangement consisted of two parts: Part 1 of the Service Arrangement comprised a standard set of terms and conditions (including quality standards, roles and responsibilities, clinical, corporate and service governance arrangements, dispute resolution and service termination arrangements). The Authority was informed that the terms and conditions contained in the Part 1 agreement were not negotiable and could not be changed. Part 2 of the service arrangement consists of a suite of schedules that were to be agreed on an annual basis between the HSE and the individual service provider. The schedules specify funding and quantum of service, performance monitoring arrangements, quality and standards to which the service must be provided, staff numbers, insurance and complaints arrangements. The Service Arrangement entitles the HSE, provided it gives 14 days notice, to withhold and set off monies owing to the Service Provider in the event and to the extent that the Provider owes any monies, damages, costs or expenses to the HSE as a result of, or in connection with, the Providers' performance or failure to perform its obligations in accordance with the Arrangement. In the event of a Service Providers' serious breach of the Arrangement, the HSE can terminate the Arrangement by giving the Service Provider three months' written notice. Service providers are also required to complete a Business Plan which sets out the activity levels and targets for the hospital for the year.⁽⁴⁸⁾

11.5.2 Service Arrangement Requirements and the Hospital

The Authority found that the first Service Arrangement, Part 1 and 2, between the HSE and the Hospital was signed on 15 May 2010 following lengthy negotiations between the HSE, the Hospital and the Hospital's legal advisors. However, this was not ratified by the Board of the Hospital until 29 July 2010. Part 1 of the Arrangement covered the period from 1 January 2010 until 31 December 2011.

11.5.3 Governance evaluation

The HSE requires all new service providers in receipt of Section 38 funding to complete a Supplementary Supporting Information Form⁽⁶⁸⁾ and a Governance Self-Evaluation Questionnaire.⁽⁶⁹⁾ However, the Authority was informed by the HSE that the Hospital was an established Service Provider and accordingly the HSE did not require it to complete this. The Service Arrangement required the Hospital to have effective internal codes of governance in place including an adequate system of internal controls to ensure compliance with laws and regulations, use the *Code of Practice for the Governance of State Bodies* publication⁽⁴⁶⁾ and promptly notify the HSE, in writing, of any serious concerns in relation to governance together with a proposal to address these concerns.

A number of HSE representatives who were interviewed stated that the HSE had concerns in relation to the effectiveness of the governance of the Hospital but that the terms and conditions of the Service Arrangement did not allow the HSE to impose sanctions other than those described in 11.5.1. However, these concerns were not recorded in the regional or national risk register nor was the Authority provided with any written information about these concerns. From information available to the Authority, it did not appear that there was evidence to demonstrate that the Hospital complied with the Section 38 requirement to promptly notify the HSE, in writing, of any serious concerns in relation to governance together with a proposal to address these concerns.

11.5.4 Annual Report

The Hospital was also required to keep detailed records in respect of its performance and submit an annual report⁽⁶⁷⁾, which included information on the governance arrangements and a report on the implementation of the Business Plan together with the audited accounts, to the HSE no later than June 2010. The Authority found that the Hospital submitted audited financial accounts for 2009 and 2010 to the HSE. There was no Annual Report submitted to the HSE in 2010 or 2011. The Authority did not find any information as to how the HSE pursued this. The Authority sought copies of Annual Reports for 2010 and 2011 from both the HSE and the Hospital but was advised that these were not in existence.

11.5.5 Scope of services

The Service Arrangement required that the determination of the scope of services to be provided and the available capacity of the Service Provider be analysed to determine the appropriate type, range and volume of the services which the HSE would fund and for this to be outlined in a schedule. The Arrangement also outlined that if Service Providers provide services outside the scope of the agreement (unapproved services), then they were solely responsible for any obligations or liabilities incurred.

The Authority was not provided with any information by the HSE or the Hospital as to the scope of approved or unapproved services. Rather, it found that the volume of some of the services that the Hospital was providing had increased due to unilateral agreements between individual consultants without any reference to the Executive Management Team of the Hospital and in the absence of any transfer of resources.

The Authority was informed that the scope, type and volume of some services provided at the Hospital had increased or changed without the approval of the HSE. There were examples provided to the Authority that consultant posts were requested by the Hospital and approved by the HSE without evident consideration of all of the implications on the capacity of the Hospital to provide any additional diagnostic services internally and to the community, or the impact

of these appointments on patients already waiting for services. In addition, the Authority found that there were additional unintended consequences due to the proposal and approval of consultant posts by the Clinical Care Programmes. The appointment of individual clinical specialists, in the absence of a clear service model and managed plan, may have had an impact on other services.

The Authority did not find information to demonstrate that there was a clear service model or scope of services described for the Hospital. The approval and appointment of an additional neurologist, in the knowledge that there were excessive delays in accessing radiology diagnostics, in particular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) for inpatients, hospital outpatients and GP referred patients, is an example of this. In addition, the Authority was informed that the Hospital's founding organisations, the Adelaide Hospital Society and the Meath Hospital Foundation, provided funding towards new services, consultant appointments and research that had an impact on the level of service delivery. On the basis of the information available, there was no apparent evidence that the unintended consequences of this additional funding were considered in the context of the Service Arrangement.

11.5.6 Service funding

The Authority found that Part 2 of the 2010 Service Arrangement outlined that funding of €189 million, with an employee ceiling of 2597, was provided for services which were authorised by the HSE. Minutes of a meeting record that in February 2010, the Hospital advised the HSE that the 2010 budgetary overrun was in the region of €4.5million and discussions were held in relation to a breakeven plan for 2010. In July 2010, the meeting minutes indicated that the Hospital advised the HSE of the predicted overspend of €6.7 million in 2010 but that a breakeven would be achieved in 2010.

The Authority was informed that multiple conflicting priorities contributed to the budget overspend and overrun of activity. Examples provided included the requirement to reduce patient activity while meeting national colonoscopy waiting times and to address the elective orthopaedic patient waiting list at a time when the HSE was aware that there were on average six patients per day waiting more than 12 hours for admission from the ED. Meeting the required colonoscopy and orthopaedic initiatives accounted for 1193 patient discharges out of the total of 1470 patient activity which was ahead of the yearly target in 2010. The Authority did not find any information as to how the implications of these initiatives were considered in relation to the impact on resources and the risk-benefits for all patients who required care from the Hospital.

11.5.7 Service Agreement and the catchment area

The Authority found that the Hospital advised the HSE that strict enforcement of its catchment area was required if breakeven was to be possible. In the case of the provision of acute services in Dublin South/Kildare-West Wicklow area, there are two hospitals providing scheduled and unscheduled acute care, these being Naas General Hospital and AMNCH. The Authority found that the HSE monitoring reviews in relation to the provision of services and the resources available and catchment within the Dublin Mid Leinster (DML) region were held unilaterally with the service providers. The Authority did not find information to suggest that there was a forum for all of the hospitals within the Dublin Mid Leinster region to discuss the totality of resources, demand and capacity. This would suggest that there was not a mutual understanding of the collective roles and responsibilities of each hospital's contribution to the overall delivery of the Dublin Mid Leinster service plan as part of the National Service Plan for the delivery of health services to the population.

In April 2011, the HSE wrote to the Hospital requesting their expeditious sign-off of the 2011 Part 2 Service Arrangement. This service proposed a reduced funding and employment ceiling in line with the reduced allocations to DML with activity levels aligned to the service delivery priorities set down in the NSP. The proposed 2011 Service Arrangement is laid out in Table 24.

The 2011 Service Arrangement was signed by the Hospital, following extensive engagement, in September 2011.

Table 24 Proposed 2011 Service Arrangements for the Adelaide and Meath Hospital Dublin, incorporating the National Children's Hospital, Tallaght

Budget € (m)		Employment Ceiling (whole time equivalent)		
176.438		2464.01		
Expected Activity 2011				
Inpatient Discharges	Day Cases	Outpatient Attendances	Emergency Presentations	Emergency Admissions
17,813	30,154	221,202	74,261	20,616

Source: HSE Service Plan

11.6 HSE review of Service Arrangement

The Authority found that there was no single point of contact within the HSE that the Hospital could engage with and there was no clear single formalised integrated corporate and clinical governance oversight or accountability system in place. The existing arrangements between the HSE and the Hospital often acted as layers through which, Hospital representatives stated, it was hard to secure decisions and approvals.

The Service Arrangement⁽⁴⁸⁾ required the HSE to monitor the standard of performance of the Hospital and its implementation of the Service Arrangement through Review Meetings. The Authority was informed that the Dublin Mid Leinster area management structure focused on performance management.

In addition, the Quality and Patient Safety Directorate in the HSE, established in 2010, was responsible for the development of patient safety and quality, clinical governance arrangements and determined the integrated risk management arrangements to be followed for HSE and HSE funded services. It liaised with the Hospital in a developmental way and also carried out audits.

Similarly, the National Clinical Care Programme provided support to clinical and management teams in the Hospital for the development of strategies for the best operating models of care provided by the Hospital.

The HSE's National Cancer Control Programme also engaged with the Hospital in relation to the provision and discontinuation of certain cancer services and the HSE's Estates Directorate engaged with the Hospital in relation to capital funding.

11.6.1 Review meetings

The Authority found that both the agenda and the minutes of the Review meetings between the HSE and the Hospital did not follow a structured format which aligned them to the Service Arrangement and had no action tracker in place to ensure that decisions and actions were tracked. The main tenor and focus of the meetings were on the budget and breakeven plan. In five out of the six meetings held in 2010, the budget and breakeven plan was the first item on the agenda whereas the quality, safety and governance of the services being provided by the Hospital was not an item on the agenda. It appeared to the Authority that based on the information available to it, the safety of patients or clinical outcomes was not monitored by the HSE or the implications of the financial overspend considered in these terms over this time. However, in the minutes of the June 2011 meeting, it was noted that a member of the HSE Quality and Patient Safety Directorate was to become a standing member of the review meeting. The minutes of this meeting also reflect that the HSE advised the Hospital that it was their intention to increase their monitoring role in relation to governance at the Hospital noting that they had not seen the documentation sent to the Authority.

The HSE HealthStat Dashboard⁽⁵⁴⁾ indicated that the Hospital did not meet a number of the HSE access, integration or resource targets including the Emergency Department to Acute Admission Waiting Time, and Finance and Resource Usage targets from Jan 2010 to May 2011. However, the minutes of the meetings do not reflect that this failure by the Hospital to meet targets was discussed at the Review Meetings in terms of quality or safety of services provided to patients.

The Authority was informed that, during 2011, in line with national policy, the Hospital submitted a new quality, safety, risk and development plan to the HSE. This plan reflected quality improvements in relation to hygiene, decontamination, healthcare records management, infection control and integrated discharge planning.

The Authority found that the HSE did not effectively use the Service Arrangement as a framework for managing, monitoring and reporting on the Hospital's performance in relation to governance.

11.7 HSE response to concerns raised by the Authority

Both the HSE Regional Directorate and Quality and Patient Safety Directorate were at the meetings at which the Authority raised concerns about the matter of patients being accommodated on corridors outside the ED awaiting admission, which was accepted by the Hospital as being a normal and longstanding practice. Following a meeting between the Authority and the HSE in April 2011, it was reported to the Authority that the National Director for Quality and Patient Safety and the Regional Director of Operations changed the format of the review meetings to include a member of the Quality and Patient Safety Directorate in attendance, with the intention of increasing their monitoring role in relation to quality and safety and governance at the Hospital.

The Authority found that, in response to nationally reported waiting times for patients on trolleys in the ED, the HSE had introduced a system wide full capacity protocol⁽⁶⁰⁾ with a threshold of full capacity identified by each hospital. HSE interviewees indicated that the HSE had concerns about the quality of services provided to patients accommodated in the ED at the Hospital. However, the Authority found that this risk, although identified on the regional risk register, was not escalated to the national risk register for consideration at the HSE Board. A number of those interviewed said that a Hospital-wide response was necessary to reduce the numbers of patients waiting on trolleys and accordingly the HSE's focus was on longer term risk mitigating actions. These included the development of the National Clinical Programmes whose three objectives are access, quality and efficiency.

At interviews, it was said that the HSE had discussed reducing the number of patients occupying trolleys at the Review Meetings with the Hospital but acknowledged that the minutes of the meeting did not reflect the extent of these discussions. The Authority found that the HSE had provided an additional €100,000 to assist with a patient streaming project for the ED. In addition, a member of HSE staff was assigned to the Hospital to assist with this project, including discharge processes. However, at the time of the commencement of the investigation this project had not been completed.

In April 2011, following the death of a patient in the ED, the Authority wrote to the Hospital and the HSE outlining its concerns about the safety of these patients and sought assurances from the Hospital as to how the risks to patients were being assessed and the immediate actions taken to mitigate the risks. The Authority asked the Hospital to provide a copy of the internal review of the case of the death. The HSE representatives, who were interviewed, indicated that the HSE did not request the Hospital to cease using the corridor to accommodate patients but rather focused on the long-term solutions. For example, the HSE arranged improved access to diagnostics, by outsourcing ultrasounds and CTs on a contract basis, and sanctioned the recruitment of additional radiology staff. The HSE was aware that the Authority had previously requested the Hospital to mitigate the immediate potential risks to patients rather than just paying attention to the medium and longer-term solutions.

The Authority found that the HSE did not respond in a timely and appropriate manner to the Authority's concerns about the potential risk to patients being cared for in the corridor adjacent to the ED in the Hospital. It is of significant concern that this again highlights the inability to apply system-wide learning. The Authority had previously identified in its *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at Mallow General Hospital*⁽⁶⁾ that there was a need to identify and address clinical risks to patients and manage them in a proactive way in advance of planned longer-term changes. This repetitive failure to learn may result in continued unnecessary adverse outcomes for patients.

11.8 Conclusions

11.8.1 Planning, accountability and oversight arrangements

At the time of the investigation, the HSE was the statutory body with responsibility for delivering health and personal social services in Ireland. The objective of the HSE is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public. The HSE entered into an arrangement to provide public funds of €189,145,846 to the Hospital to deliver services on its behalf and was responsible for holding the Hospital to account in doing so. In 2010, the Hospital agreed to

these arrangements and accepted these funds to deliver services on behalf of the HSE. However, during that period there were a number of changes in the senior management in the Hospital, all of whom were required to revert to the Hospital's Board for decisions and this contributed to the confused governance.

The Authority found that the arrangements in place to govern the relationship between the HSE and the Hospital were not effective. The Service Arrangement was not effective or used by the HSE to its full potential as a framework to seek the necessary assurances from the Hospital that the services they were funded to provide, on behalf of the HSE, improved, promoted and protected the health and welfare of patients in the most efficient and effective manner possible.

The governance arrangements and the accountability to the HSE were not fully understood by the Hospital with some Board Members questioning the legitimacy of the HSE's interest in the Hospital's service, activity and efficiency. The Authority found that the Hospital did not comply with all the terms set out in the Service Arrangement. The HSE interviewees stated that there were limited sanctions for the HSE to impose other than withholding funds and that this could potentially negatively impact on patient care. Consequently, it was indicated that the HSE focused its efforts on providing support and stability in particular, during the period of change of the senior management team at the Hospital as a means of governing the relationship between the HSE and the Hospital.

The funding of the Health Service has historically relied upon a model of incremental budget increases. This has the potential to perpetuate historical inequalities that were sometimes related to provider supply and clinician practice patterns that did not consider the entirety of service demand requirements and available capacity. In the absence of a blueprint for the totality of service provision, and decisions about models of service, individual provider preference and professional influence may overshadow the common good of population and patient groups.

A population needs-based allocation that reflects demand and capacity is essential to readjust any imbalances between provider-focused and population-focused healthcare services – particularly while the health system is undergoing considerable transformation at local, regional and national levels. However, such a model needs to recognise the need for research and innovation and ensure the associated potential benefits for future patients are not eclipsed.

It did not appear to the Authority that there was reconciliation between the funds available, the budgetary overspend, catchment areas, innovation and research, demand and capacity and the core business of delivering high quality safe care to patients.

There was no evidence available to the Authority to demonstrate a clear understanding of the collective roles and responsibilities of each statutory and non-statutory hospital's contribution to the overall delivery of the DML service plan as part of the HSE's National Service Plan. The HSE did not describe a service

model and there was no clear direction provided for the Hospital. However, there were in place a number of national policies, including the National Cancer Care Programme, which could have informed the direction.

The Authority concluded that there was a multiplicity of factors present in the actual governance arrangements between the HSE and the Hospital that may have contributed to the failures that led to weak governance, substantial and longstanding budgetary overrun and ultimately, care being persistently provided to patients in the corridor adjacent to the ED in the Hospital.

The Authority found that there were not effective arrangements in place to govern the HSE relationship with the Hospital, including the functions of performance monitoring and performance management of the services being provided by the Hospital. This was facilitated by the Health Act and the negotiated Section 38 Service Arrangement that did not identify appropriate controls and sanctions to manage, monitor and address persistent poor performance. Notwithstanding this, there was nothing to preclude the effective management of the Hospital's performance by the HSE.

11.8.2 National perspective

From a national perspective, currently, there is no formalised arrangement for the performance management (including financial management, quality and safety and performance and delivery) of the chief executive of health and social care service providers in receipt of State funds, as the accountable officer who may be responsible for significant amounts of public money, outside of the board reporting line to the chairperson. Similarly, there are currently no reporting lines for a chairperson, with ultimate accountability for the provision of services by that service provider, and outside of any arrangements in place with the board, to be held accountable for the performance of the board in the provision of the services, the effectiveness of its governance and in holding the chief executive to account.

In a system that is facing considerable challenges, the effectiveness of the governance arrangements through which public funds are allocated, defined and performance managed is essential. This requires the establishment of a clearly defined 'Operating Framework' for the State that outlines the key elements for the effective governance and operation of a high quality, safe and reliable health and social care system which is optimally designed to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy. The core elements of this framework should include:

- clarity of the types of services provided in different types of facilities
- the process by which specialist services are identified, resourced, delivered and monitored

- the basis of resource allocation for defined services and service providers and a provision for variation of services
- clear principles outlining the Provider and the Commissioner roles and responsibilities
- an effective and deliverable contractual arrangement between the Provider and the Commissioner
- the line management relationships between the chairpersons and chief executives of all hospitals (in the first instance) in receipt of State funding to nationally designated post-holders (with the roll out of similar appropriately aligned line management arrangements to other service providers in receipt of State funds as required – including social care providers and primary care providers that may be established in the development of future policy)
- structured quarterly and annual accountability reviews with the chairperson and chief executive of each hospital through a defined mechanism
- defined national key performance indicators for the various types of service providers that measure core aspects of the business and include quality and safety, patient/service user experience, access to services and financial management that are made publicly accessible
- a clear performance management framework that addresses issues of persistent poor performance of a service provider in receipt of State funds.

Currently, there is no nationally deployed resource to support hospitals (and other health and social care organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development programmes to build capacity and capability within such organisations.

In addition, to strengthen the performance management arrangements that are currently in place in order to address potential issues of persistent poor performance, a Special Measures Framework should be established to actively address and act on circumstances in which substantial poor performance of the board and/or executive management of a service provider in receipt of State funds occurs. This Framework should contain the provisions for intervention orders where the Minister for Health, or delegated individual or Agency (for example the Chief Executive or future Director General of the HSE), believes that a hospital (or other designated service provider) is not performing one or more of its functions adequately or at all, or that there are significant failings in the way it is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene. In such circumstances, an intervention order should be made.

Given the significant system-wide governance recommendations outlined in this Report, it will be imperative that there is the necessary political commitment to their managed implementation in order to drive further improvements in the quality, safety and governance of the care provided in our health system. The Authority therefore recommends that the Minister for Health should establish, as a priority, an oversight committee in the Department of Health to ensure the implementation of the governance recommendations in this Report. The committee should report to the Minister and include international expertise in the area of governance and also patient representation.

Recommendations – Planning, Accountability and Oversight

Planning

1. The Department of Health should develop a national plan defining what tertiary and quaternary specialist services should be provided at which facility across the country, or contractually by other jurisdictions, based on informed factors including population need, forecasted activity and geographical distribution. This should be determined and implemented in advance of the universal health insurance system.
2. A comprehensive analysis, rationalisation and re-organisation of the distribution and provision of the types, number and operational times of (specific types of) hospital services in the Dublin area should be undertaken by the Department of Health and the HSE. The analysis should be based on current and future forecasted population demographics, needs, demand, activity, resource requirements and service utilisation. The analysis should inform the development and implementation of a Dublin Regional Healthcare Services Plan in order to provide the optimum services required to best meet the needs of the population in the most effective and efficient way.
3. A population and policy-informed needs-based allocation for health services in Ireland, that reflects current and future demand and capacity, should be undertaken by the Department of Health. Such a model should recognise the need for research and innovation where appropriate and should inform the resource-base for the modernising of service configuration.

Accountability and Oversight

4. The Department of Health should establish an Operating Framework for the health and social care system that outlines the key elements for the effective operation of a high quality, safe and reliable health system which is optimally designed and held to account to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy. The core elements of this framework should include:
 - clarity of the types of services provided in different types of facilities
 - the process by which specialist services are identified, resourced, delivered and monitored
 - the basis of resource allocation for defined services and service providers and a provision for variation of services
 - clear principles outlining the provider and the commissioner roles, responsibilities and relationship
 - an effective and deliverable contractual arrangement between the provider and the commissioner.

- 5.** Structured quarterly and annual accountability reviews with the chairperson and chief executive of each healthcare provider in receipt of State funds (in the first instance hospital services) should be established through a defined mechanism involving, for example, the director of hospital services and the Chief Executive of the HSE, or the future Director General of the HSE.
- 6.** The Department of Health should ensure that a suite of national key performance indicators for hospitals that measure core aspects of the business and include quality and safety, patient experience, access to services and financial management are developed. These should be collated, monitored and managed by hospitals in receipt of State funds and reported publicly.
- 7.** The Department of Health should put in place a Special Measures Framework to actively address and act on circumstances in which substantial poor performance of the board and/or executive management of a hospital occur. This Framework should contain the provisions for intervention orders where the Minister for Health, or delegated individual or agency (for example the chief executive or future Director General of the HSE), believes that a hospital is not performing one or more of its functions adequately or at all, or that there are significant failings in the way the hospital is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene. In such circumstances, an intervention order should be made.
- 8.** A nationally deployed resource to support hospitals (and other healthcare organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management should be established. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development.
- 9.** The Minister for Health should, as a priority, establish an oversight committee in the Department of Health to ensure the implementation of the governance recommendations contained within this Report. The Committee should report to the Minister for Health and include international experts in the area of governance and also patient representation.

Part 4

Conclusions and moving forward

12 Conclusions

This investigation was instigated by the Authority in response to a lack of assurance that the Hospital was effectively identifying and managing the risks to patients requiring acute admission at the Hospital. The Authority concluded that the continued use of the corridor adjacent to the ED to accommodate patients who required acute admission while awaiting transfer to an inpatient bed at the Hospital was a symptom of ineffective leadership, governance and management.

In carrying out the investigation, the Authority looked in detail at the safety, quality and governance of the system of care in place for patients who required acute admission to the Hospital, in particular, those admitted through the Emergency Department (ED). Similarly, and in recognition of the interdependent relationship between the management of the patient admission process for patients requiring unscheduled care and admission and those requiring scheduled care and admission, the Authority investigated both admission processes at the Hospital.

The investigation also considered the effectiveness of the Board of the Hospital, the Hospital's Executive Management and the Health Service Executive (HSE), in discharging their respective responsibilities in order to be assured that risks to patients were being appropriately managed by the Hospital.

Finally, for the purpose of system learning, the investigation incorporated a national perspective in relation to each of these elements in order for the lessons from this investigation to benefit patients receiving care in hospitals all over the country and to improve the way the system currently oversees, performance manages and governs the delivery of healthcare across the State.

12.1 Unscheduled care

At the time of the investigation, the Hospital reported that the ED had received 20,522 adult emergency department attendances over the period of January to June 2011. Of this, 31% of these patients were admitted to the Hospital.

The patient referral pathways to the Emergency Department of the Hospital were considered to be similar to those of other hospitals in Ireland with a similar patient profile and the majority of patients being self-referred. The lack of an out-of-hours general practice or primary care service in the area meant that patients and / or their GPs may have felt that they had no other option but to attend or refer the patient to the Hospital's Emergency Department in order to accelerate their treatment.

The Authority found that, of the total number of patients who attended the ED for the first six months of 2011, 14% left without completing their care. Whilst there may be a range of reasons why these patients left, for example, waiting long periods, there is a risk that patients who leave may have underlying health conditions which could deteriorate without treatment.

The patient and the hospital must know who is in charge of the patient's care at all times. Whilst the patient was in the ED and Clinical Decision Unit in the Hospital, they were reported as being under the care of the emergency medicine consultant. However, at the time of the investigation, the Authority found that the designated consultant with responsibility for the patient's care, when the patient was referred by the emergency medicine team to an in-house specialty team elsewhere in the hospital, was not clear following this referral and prior to the patient's acceptance by the in-house specialty team. This ambiguity posed a potentially serious risk to patient's health and welfare. Consequently, the Authority raised this with the Chief Executive of the Hospital during the course of the investigation who responded with assurances that an operational policy had been fully implemented to ensure that the patient was under the care of a consultant at all times, and that monitoring mechanisms around this had been put in place.

12.2 Patient journey for unscheduled care

At the time of the investigation, the Authority found that the mean waiting time for a non-admitted patient in the ED was in the spectrum of six to seven hours. However, the Hospital also reported patients waiting within the ED for up to 61 hours before being discharged.

Of the total number of admitted patients through the ED for the three-month period between April and June 2011, a mean of 86% were allocated to wait on the corridor adjacent to the ED to await transfer to an inpatient facility. Patients could be waiting an average of 13 hours, with the longest reported time being reported as long as 140 hours, before being transferred to an inpatient ward. This corridor was a main thoroughfare for people and patients attending the X-ray department. Ill patients lay waiting on patient trolleys or sat on armchairs, with an insufficient level of privacy or dignity. The physical congestion and absence of basic facilities associated with the use of the corridor as a waiting area for ill patients compromised the quality and safety of care for these people and also compromised the assessment of newly arriving patients in the ED.

The use of the corridor at the Hospital was wholly unacceptable to the Authority and it prompted an unannounced inspection by members of the Investigation Team to the ED on 24 August 2011.

12.3 Unannounced inspection of the ED at the Hospital from 09:00 hours to 11:30 hours on 24 August 2011

Based on the information received prior to the unannounced inspection, and what was observed on the morning of this inspection, a number of issues were identified which the Authority believed to have the potential to pose serious risks to the health and welfare of persons receiving unscheduled acute care at the Hospital. The Authority wrote to the Chief Executive of the Hospital on 25 August 2011 requiring the cessation of the use of the corridor adjacent to the ED by 1 September 2011. The Hospital's Chief Executive confirmed to the Authority on 29 August 2011 that the use of the corridor adjacent to the ED for the accommodation of patients had ceased. (See Appendix 8.)

12.4 National emergency department performance on 23 to 24 August 2011

In tandem with the data received during the course of the unannounced inspection of the ED at the Hospital for the 24-hour period of 23 to 24 August 2011, the Authority reviewed the national data submitted for the ED patient attendances across the country for that same day which had been provided and validated by the HSE. The data returned was not consistent in the level of detail provided by all 33 hospitals providing various levels of emergency department services.

From the data that was received, the Authority was concerned that patients attending the majority of EDs in Ireland experienced waiting times of greater than six hours, with the longest waiting times up to 115.49 hours for discharge and 137.48 hours for admission.

Waiting times for patients in Ireland's EDs has been a longstanding concern from a patient safety and quality, patient advocacy and service provider perspective. This came to the fore in 2007 when the HSE published the Emergency Department Taskforce Report, which contained a number of recommendations to be implemented across all EDs in Ireland. It is not acceptable that, at the time of the investigation in 2011, the HSE and hospitals providing emergency department services on its behalf still did not have adequate information gathering and analysis processes in place to performance manage their EDs from a patient experience and timeliness perspective. Service providers accountable for providing ED services cannot effectively manage and improve services for patients in the absence of this.

The findings of this phase of the investigation identified potential risks to patients associated with long waiting times in an ED and also an absence or lack of available data. This suggests that the system of care is not being as actively managed as it should be. In view of the serious nature of these risks, the Authority wrote to the then Secretary General of the Department of Health on 1 February 2012 and requested that the Special Delivery Unit of the Department of Health, in its capacity of performance managing ED wait times, review and address these issues as a matter of priority (see Appendix 9).

12.5 Scheduled care

At the time of the investigation, work was ongoing at the Hospital to improve the outpatient services whilst also implementing the recommendations of the Hayes Report.

However, further to the findings of the investigation, the Authority concluded that extended waiting times for both inpatient and outpatient diagnostic imaging at the Hospital, as well as diagnostic reporting turnaround times, required further review and improvement. This included the requirement to implement a process for the identification and prioritisation of diagnostic testing based on patient need. In addition, the implementation of an electronic critical alert system was required to ensure the timely information regarding a patient's diagnosis.

At the time of the investigation, the Hospital was outside the national average length of patients stay of 5.9 days, with an average length of patient stay of 6.86 days being reported in June 2011. One significant step in reducing patient length-of-stay safely is to ensure that structured ward rounds by senior clinical decision makers are undertaken daily. At the time of the investigation there was disparity in the frequency of ward rounds and proactive patient discharge planning was not consistently supported by all clinical disciplines. In recognition of the problem, the Hospital had begun to implement operational strategies in relation to bed management practices, active discharge planning practices, ward rounds and day-of-admission processes in order to improve performance against the HSE national target for the Average Length of Stay for admitted patients.

In order for the safe, timely and appropriate discharge of patients from hospital who may require ongoing care, a particular focus must be placed on ensuring that the local, regional and national arrangements are in place to ensure that appropriate community, intermediate, short-term and long-term residential facilities are available to patients and their families for the purpose of effective person-centred discharge planning.

From January to August 2011, scheduled procedures for a total of 1489 patients were cancelled. Of those, 41% (n=613) were cancelled by the Hospital, 37% (n=545) by patients' consultants and 22% (n=331) by the patients – this is not acceptable. It is important that elective surgery and scheduled diagnostic and therapeutic access for patients is managed, protected and waiting times informed, based on patient need. If it is not, patients may be at risk and may perceive that they have no other option but to seek alternative means of accessing healthcare, for example through the emergency department. It is imperative that hospitals, the HSE and the Special Delivery Unit implement and monitor efficiency strategies to actively maintain timely patient access to both scheduled and unscheduled care.

12.6 Board governance

The Authority found that the Board of the Hospital did not have effective arrangements in place to adequately direct and govern the Hospital nor did it function in an effective way. The Charter was not in line with modern corporate governance. The amalgamated organisation which was merged in 1996 continued to embrace a number of different legacy beliefs, activities and cultures, lacked an organisation-wide strategic vision and culture, and failed to adequately respond to the significant changes in healthcare delivery and advances in modern corporate governance. The collective membership of the Board did not reflect the relevant diversity of knowledge, skills and competencies required to carry out the full range of oversight responsibilities necessary for the Hospital at this juncture. Nor was the appointment process in line with modern governance principles.

The Charter provided for the establishment of a number of committees which were required to report to the Board in relation to their activities. These committees included Clinical Governance, Resource and Audit. In addition, following an external review of the governance arrangements in the Hospital in 2009, which had been commissioned by the Board, in 2010 the Board established a Transitional Board of Management to manage the activities of the Hospital.

These Board committees, with the exception of the Transitional Board of Management, had no executive powers but rather advised, reported to and made recommendations to the Board. The committees were working at an operational level and did not have a framework in place to provide the necessary assurances to the Board. The Authority found little information as to how the Board or any of its committees oversaw and sufficiently assured themselves that the Hospital was delivering services in line with the HSE as articulated in the Section 38 Service Agreement for the resources provided.

As a result of these findings, during the investigation, the Authority wrote to the Minister for Health outlining a number of serious concerns that it had identified from the preliminary findings of the investigation at that point. The Authority indicated that given the significant quality and safety challenges, the financial shortfall and the need to rebuild patient confidence that were being faced by the Hospital, there was an urgent need to have an effective governing Board (Chairperson and Non-Executive Directors) in place to effectively lead, govern and support the Chief Executive and the Executive Management Team to direct and manage these challenges.

On 9 November 2011, the Minister for Health, and the Church of Ireland Archbishop of Dublin, announced a series of new initiatives to reform and modernise the governance structures of the Hospital over two phases. The first phase was a further reduction in the size of the Hospital Board occurring through the appointment of an interim Board and, in the longer term, the Charter was to be replaced. The first meeting of the new interim Board of the Hospital took place on 21 December 2011 with new members of the Board being nominated with consideration of their competencies to undertake the role.

In addition, during the course of the investigation, information came to the attention of the Authority that raised concerns about the effectiveness of the governance arrangements in place for financial management, financial transparency and commitment control. In particular, the Authority was concerned that the Hospital might not have had the internal controls in place to ensure its compliance with public procurement legislation. The Authority also had concerns about the HSE's budgetary and performance oversight of the Hospital in accordance with the funding arrangements for the Hospital by the HSE, pursuant to Section 38 of the Health Act 2004⁽⁴⁸⁾ as amended. Consequently, on 24 February 2012, the Authority wrote to the then Comptroller and Auditor General (Appendix 11) advising that the Authority had identified potential serious risks in relation to the lack of effectiveness of the governance arrangements in place at the Hospital.

The governance at the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital needs to change. The current Charter is not in keeping with modern corporate governance and should be replaced by the necessary legislative means to establish a fit-for-purpose Board that will be constituted in such a way as to be enabled to drive the necessary changes required. The primary function of the first newly appointed Board will be to effectively lead, govern and stabilise the significant financial management and quality and safety challenges and the deficits in governance and management that need to be addressed in the Hospital. With the right leadership, future Boards will then be able to strategically lead and oversee the evolution of the Hospital into a strong, high quality provider for its community well into the future.

12.7 Executive management

The Executive management arrangements at the Hospital had, over the past three years, gone through a number of significant changes, with five members of staff acting in the role of Chief Executive. There was no scheme of delegation from the Board to the Chief Executive or to the Executive Management Team for delegating accountability in relation to the delivery and performance of the Hospital's functions. This meant that the Hospital Board formally retained the dual function of governance and executive management to include quality and safety arrangements.

It was of concern to the Authority that there was a reported ambiguity as to who had overall Executive accountability for the quality and safety of the services delivered, and an apparent lack of integration across the corporate and clinical governance arrangements that were in place. This meant that the effective management arrangements that were needed to facilitate the delivery of high quality, safe and reliable care and support by allocating the necessary resources through informed decisions and actions were not sufficiently in place.

At the time of the investigation, the Authority found that historically, there was evidence that the Hospital had not adequately planned or controlled the scope and, or expansion of the clinical services provided. However, there was evidence that

the Hospital was developing programmes for improvement including policies and programmes to deliver improvement in OPD turnaround times, bed management and patient discharge planning.

The turnover of senior executives in the Hospital, and the ongoing 'acting' status of individuals in key positions, created challenges in leadership, management, stability, decision making, confidence and authority. This had the potential to impact on the ability of the Hospital to effectively address the quality, safety and financial challenges that it faced.

12.8 Planning, accountability and oversight arrangements

At the time of the investigation, the Authority found that the arrangements in place to govern the relationship between the HSE and the Hospital were not effective. The Service Arrangement was not effectively used by the HSE to its full potential as a framework to seek the necessary assurances from the Hospital that the services that it was funded to provide, on behalf of the HSE, improved, promoted and protected the health and welfare of patients in the most efficient and effective manner possible.

In addition, it did not appear to the Authority that there was reconciliation between the funds available, the budgetary overspend, catchment areas, innovation and research, demand and capacity and the core business of delivering high quality safe care to patients.

There was no evidence available to the Authority to demonstrate a clear understanding of the collective roles and responsibilities of each statutory and non-statutory hospital's contribution to the overall delivery of the HSE's Dublin Mid Leinster service plan as part of the HSE's National Service Plan. The HSE did not describe a service model and there was no clear direction provided for the Hospital. However, there were in place a number of national policies, including the National Cancer Control Programme, which could have informed the direction.

The Authority concluded that there was a multiplicity of factors present in the actual governance arrangements between the HSE and the Hospital that may have contributed to the failures that led to weak governance, substantial and longstanding budgetary overrun and ultimately, care being persistently provided to patients in the corridor adjacent to the ED in the Hospital.

The Authority found that there were not effective arrangements in place to govern the HSE relationship with the Hospital, including the functions of performance monitoring and performance management of the services being provided by the Hospital. This was facilitated by the fact that the Health Act 2004, and the negotiated Section 38 Service Arrangement, did not identify appropriate controls and sanctions to manage, monitor and address persistent poor performance. Notwithstanding this, there was nothing to preclude the effective management of the Hospital's performance by the HSE.

12.9 The national perspective

In order to ensure that existing and future individual hospitals, or network of hospitals, are led and governed effectively in a way that reflects the requirements of good corporate and clinical governance, it is imperative that the composition, membership, competencies and focus of a Board are suitable for its purpose. It is equally essential that the capacity and capability of leaders and senior managers in healthcare organisations, and the wider health system, have the core competencies and capabilities to successfully lead, manage and execute the challenges and requirements of running a healthcare organisation.

Given the substantial amount of public money that is entrusted to service providers that are in receipt of State funds, there should be a robust mechanism in place to oversee the recruitment, appointment, performance and replacement of Board members, chief executives and other executives of these service providers. In addition, there should be greater involvement in the performance management of the chairperson of a board by the State, and of the chief executive by the chairperson of the board and also by the State, to ensure that any service provider in receipt of State funds is providing good, safe services within the resources available.

To invest in our leaders and managers of the future, there should be clear managerial career progression pathways and training and development programmes established, for both clinical and non-clinical leaders and managers.

In a system that is facing considerable challenges, the effectiveness of the governance arrangements through which public funds are allocated, defined and performance managed is critical. This requires the establishment of a clearly defined 'Operating Framework' for the State that outlines the key elements of the effective governance and operation of a high quality, safe and reliable health and social care service which is optimally designed to deliver the most accessible service in the most cost and clinically effective way within the resources available and in keeping with national policy.

Currently, there is no nationally deployed resource to support hospitals (and other health and social care organisations) that are challenged and struggling in relation to areas such as leadership, governance, management, quality and safety, access, service design and financial management. This type of support should be able to provide development and interventions that include coordinating and supporting interim management where required, and providing tailored development programmes to build capacity and capability within such organisations.

In addition, a Special Measures Framework should be established to actively address and act on circumstances in which substantial and persistent poor performance of the board and/or executive management of a service provider in receipt of State funds occurs. This Framework should contain the provisions for intervention orders where the Minister for Health believes that a hospital (or other

designated service provider) is not performing one or more of its functions adequately or at all, or that there are significant failings in the way it is being run (including quality of care, patient safety, financial management issues), and is satisfied that it is appropriate for him/her to intervene.

12.10 Concluding remarks

The findings of this investigation reflect a history of longstanding challenges in the leadership, governance, performance and management of the Hospital which were manifest in the persistent, and generally accepted, tolerance of a wholly unacceptable practice of patients lying on trolleys in corridors for long periods of time.

It also reflects a history of a Hospital providing care to a substantial number of the population, that was allowed to struggle on despite a number of substantial governance and management issues in relation to quality, safety, planning and budgetary management which were present over a number of years. Despite a number of attempts to address the governance of the Hospital, and a number of improvement reviews having been undertaken, sufficient action was not taken by the Hospital itself or the HSE to address these issues. This reflected a failure not only in the governance of the Hospital but also in the governance of the health system that should effectively hold a service provider in receipt of State funds to account in the performance, delivery and quality of the service it provides.

Every day there are patients who receive good, safe care at the Hospital and there are patients who could receive better and safer care at the Hospital. The staff whom the Investigation Team met were committed to providing good, safe care and to improving the services that the Hospital provides. Going into the future, the challenges for the Hospital will be to drive, inject and embed strong personcentred leadership throughout the Hospital, in order to establish and sustain a strong culture of patient safety where all individuals involved in the Hospital have the primary focus of providing good safe care for the community that they serve.

And, in so doing, behaviours and practices that result in unacceptable care for patients are simply not tolerated and a culture of openness, transparency and driving continuous improvement is supported, actively managed and led into the organisation.

Since the investigation commenced, there have been significant changes and improvements in the Hospital which include the establishment of an interim Board (on the way to replacing the Charter) and establishing a modern and fit-for-purpose board that reflects good corporate and clinical governance, a changing leadership team that is taking initiative and driving change within the Hospital and tangible improvements in the system of care within the Emergency Department at the Hospital. These developments are referred to in Appendix 13 of the Report which has been submitted by the Hospital and outlines the progress made by the Hospital since the investigation commenced.

This investigation is a seminal point in the journey to modernising the way we run our health system. The business of person-centred health care is far too important to be run, managed and governed in a way that does not reflect a high performance, high quality and high delivery mindset – from patient to policymaker. Ignoring persistent poor performance and not having, or using, the levers and drivers in place locally and nationally to share good practice and to support and address poor performance is no longer acceptable in a modern day health system. This must change. The findings and recommendations from this investigation focus on the improvements required in the Hospital, those required in similar hospitals, the changes necessary to improve the provider/'commissioner' oversight and accountability relationship and, finally, the improvements necessary for effective governance of the health and social care system by the State.

12.11 Moving forward

This investigation includes recommendations for improvement that are specific to the Hospital and also apply nationally. The Hospital will be required to develop an implementation plan for the recommendations which should support the improvement programme currently in place at the Hospital. Other hospitals are also required to assess themselves against these recommendations and develop an implementation plan for improvement in order to meet them.

Specifically, in relation to the existing boards of service providers in receipt of State funds and the recommendations that relate to these boards assessing themselves against the relevant recommendations within the report, the Department of Health should establish a mechanism to review the assessment and arising action plans and consider the mechanism for modernising the constitutional basis and composition of such boards where applicable.

The HSE, as the 'commissioner' and provider of services, should monitor all hospitals in receipt of State funds against the implementation plans as part of the service arrangement and as part of its ongoing performance delivery reviews with each provider.

Following the approval by the Minister for Health of the *National Standards for Safer Better Healthcare*⁽⁵⁾, and the subsequent commencement of a monitoring programme against the Standards, the Authority will be monitoring service providers against the implementation of these recommendations as part of that process. These Standards will be the first step in the trajectory of a licensing system being established in the Irish healthcare system. The recommendations of this report are consistent with, and indicative of, the objectives of the above National Standards, the future healthcare licensing requirements in Ireland and the progress towards self-governed Trusts as outlined in the Programme for Government.

Given the significant system-wide governance recommendations outlined in this Report, it will be imperative that there is the necessary political commitment to their managed implementation in order to drive further improvements in the quality, safety and governance of the care provided in our health system. The Authority therefore recommends that the Minister for Health should establish, as a priority, an oversight committee in the Department of Health to ensure the implementation of the governance recommendations in this Report. The committee should report to the Minister and include international expertise in the area of governance and also patient representation.

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15 Glossary of terms and abbreviations

Accountability: is demonstrated by the service provider accepting responsibility for their decisions and behaviours as a service provider and for the consequences for service users, families and carers.

Acetabular fracture: when the socket of the hip joint is broken.

Acute admission: an unplanned admission of a patient on the day of presentation to an admitting hospital.

Acute hospital: an acute care hospital is a facility offering surgical and medical patient care for individuals facing an unexpected medical problem that needs immediate assessment and treatment.

Acute lower respiratory infection: infection of the lower respiratory tract, which affect the airways and lungs.

Acute Medicine Programme (AMP): a national initiative that is clinician-led, providing a framework for the delivery of acute medical services which seeks to substantially improve patient care.

Admission lounge: a dedicated area of a hospital for patients who are admitted on the same day as their surgery. This is an alternative to patients being admitted to a ward prior to surgery. On arrival to the admission lounge, patients are admitted and prepared for surgery, and will wait in this lounge until their surgery.

Adolescent cardiology: a specific adolescent cardiology service.

Adult renal medicine: the branch of medicine that deals with the kidneys, especially their functions or diseases.

Advanced triage protocols: a detailed plan/pathway of a medical treatment or procedure to be initiated following triage assessment for the management of patients presenting with, for example, chest pain, sepsis (infection) or pain.

Adverse event: an incident which results in harm to a patient.

Advocacy: the practice of an individual acting independently of the service provider, on behalf of, and in the interests of a service user, who may feel unable to represent themselves.

Allied healthcare multidisciplinary group: a group of allied health professional from various disciplines who work as part of a team.

Allied health professional: encompasses clinical support specialties such as physiotherapy, occupational therapy, social work, speech and language therapy and clinical nutrition.

AMNCH: Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital.

Anaesthetic: substance that produces partial or complete loss of sensation.

Advanced nurse practitioner (ANP): an autonomous, experienced practitioner who is competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to masters degree level (or higher).

Atrial fibrillation and flutter: rapid and irregular heart beat causing palpitations and shortness of breath.

Bed management: the provision and allocation of beds in a hospital.

Calculus of ureter: kidney stone.

Cardiology: the study and treatment of medical conditions of the heart.

Care pathway: a multidisciplinary care plan that outlines the main clinical interventions undertaken by different healthcare professionals, in the care of service users with a specific condition or set of symptoms.

Casemix: the types of patients and complexity of their condition treated within a healthcare service, including diagnosis, treatments given and resources required for care.

CDU: Clinical Decision Unit.

Cellulitis: infection of the skin caused by bacteria.

CEO: Chief Executive Officer.

Chemical pathology: pathology specialty for the chemical analysis of various components of blood and urine.

Chemical pathologist: a specialist in the area of chemical pathology.

Chronic illness: A disease which lasts three months or more.

Chronic obstructive pulmonary disease (COPD): one of the most common lung diseases that makes it difficult to breathe. There are two main forms of COPD:

- Chronic bronchitis, which involves a long-term cough with mucus
- Emphysema, which involves destruction of the lungs over time.

CIS: Clinical Indemnity Scheme.

Clinical audit: a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Clinical director: the senior clinical leader with delegated responsibility and accountability for patient safety and quality throughout a healthcare organisation.

Clinical directorate: a team of healthcare professionals within a specialty, or group of specialties.

Clinical governance: a system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This includes mechanisms for monitoring clinical quality and safety through structured programmes, for example, clinical audit.

Clinical guidelines: systematically developed statements to assist healthcare professionals' and service users' decisions about appropriate healthcare for specific circumstances.

Clinical neurophysiology: the subspecialty of clinical neurophysiology involves the measurement and assessment of function of the central nervous system, peripheral nervous system and skeletal muscle for the purpose of diagnosing and treating neurological disorders.

Clinical nurse facilitator: a nursing role which aims to enhance clinical practice by supporting qualified nurses in the delivery of patient care including the promotion of continuous practice development.

Clinical Nurse Manager (CNM): a nurse more senior than a staff nurse but more junior than an assistant director of nursing. A CNM 2 is more senior than a CNM 1.

Clinical psychology: the branch of psychology concerned with the diagnosis, treatment, and prevention of a wide range of personality and behavioral disorders.

Closed bed: each hospital has an assigned bed capacity. A closed bed is taken to mean a hospital bed not actively in use for patient care; beds may be 'closed' for a period of time for a variety of reasons including as a cost containment measure, infection control or for refurbishment.

Code of governance: a description of the roles and responsibilities of those governing the service including an oversight role with clear lines of accountability in respect of safety and quality of health services provided.

Community care: help available to persons living in their own homes, rather than services provided in an institution.

Competence: the knowledge, skills, abilities, behaviours and expertise sufficient to be able to perform a particular task and activity.

Complaint: an expression of dissatisfaction with any aspect of service provision.

Concern: a safety or quality issue regarding any aspect of service provision, raised by a service user, service provider, member of the workforce or general public.

Consultant: a senior hospital doctor, including physicians, surgeons, anaesthetists, pathologists, radiologists, oncologists and others.

COPD: Chronic obstructive pulmonary disease

Core hours: core working hours can be classified as the working hours of 9am to 5pm, Monday to Friday.

Corporate governance: the system by which services direct and control their functions in order to achieve organisational objectives, manage their business processes, meet required standards of accountability, integrity and propriety and relate to external stakeholders.

Critical care services: service for the provision of medical care for a critically ill or critically injured patient.

CT: computerised tomography scan.

Culture: the shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.

Cystic Fibrosis: an inherited disease that affects the lungs, digestive system, sweat glands, and male fertility.

DATHS: Dublin Academic Teaching Hospitals.

Day ward: a ward in a hospital for day patients to stay in to recover from their treatment.

Deep venous thrombosis: a blood clot that forms in a vein deep in the body.

Delayed patient discharge: defined as a patient who has completed the acute phase of their care and are medically fit for discharge into a non-acute setting.

Dermatology: the branch of medicine that is concerned with the physiology and pathology of the skin.

Diabetes: refers to diabetes mellitus or, less often, to diabetes insipidus. Diabetes is a disease characterized by an inability to process sugars in the diet, due to a decrease in or total absence of insulin production. Diabetes mellitus and diabetes insipidus share the name 'diabetes' because they are both conditions characterized by excessive urination (polyuria).

Diagnostic imaging: the technique and process used to create images of the human body (or parts and function thereof) for the purpose of diagnosis.

Dignity: the right to be treated with respect, courtesy and consideration.

Discharge lounge: a dedicated area of a hospital for patients who have been discharged by their clinician post admission, and are awaiting final arrangements before leaving the hospital, for example, prescriptions, medication, follow up appointments or transportation.

DoH: Department of Health.

Early Warning Score (EWS): EWS is a physiologically-based system of scoring a patient's condition to help determine severity of illness and predict patient outcomes.

ED: Emergency Department.

EDD: Estimated date of discharge.

Effective: a measure of the extent to which a specific intervention, procedure, treatment, or service, when delivered, does what it is intended to do for a specified population.

Elective: an elective procedure is one that is chosen (elected) by the patient or physician that is advantageous to the patient but is not urgent.

Electronic Critical Alert System: an advanced electronic notification system designed to alert the appropriate hospital personnel about critical abnormal test results.

Emergency care: the branch of medicine that deals with evaluation and initial treatment of medical conditions caused by trauma or sudden illness.

Endocrinology: the study of hormones, their receptors, the intracellular signalling pathways they invoke, and the diseases and conditions associated with them.

ENT: Ear, nose and throat.

ESRI: Economic and Social Research Institute.

Evaluation: a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.

Evidence: data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data and evaluations.

Executive Board Member: a member of the board of an organisation who also holds or has held a position within the organisation itself.

Gastroenterology: the branch of medicine concerned with the structures, diseases and pathology of the stomach and intestines.

GMS: General Medical Services

Governance: in healthcare, an integration of corporate and clinical governance; the systems, processes and behaviours by which services lead, direct and control their functions in order to achieve their objectives, including the quality and safety of services for service users. See also '**Clinical governance**' and '**Corporate governance**' above.

GP: general practitioner, A doctor who has completed a recognised training programme in general practice and provides personal and continuing care to individuals and to families in the community.

GP liaison nurse: a role which aims to enhance communication between the emergency department and general practitioners. The role contributes to the continuity of patient care across the acute and primary care setting, and acts as an intermediary in both communication and discharge planning.

Gynaecology: the branch of medicine particularly concerned with the health of the female organs of reproduction and diseases thereof.

Haematology: the diagnosis, treatment, and prevention of diseases of the blood and bone marrow as well as of the immunologic, hemostatic (blood clotting) and vascular systems.

Haematologist: a specialist in the area of haematology.

Haemorrhage: the flow of blood from a ruptured blood vessel.

Healthcare: Services received by individuals or communities to promote, maintain, monitor or restore health.

Healthcare Associated Infections: infections that are acquired as a result of healthcare interventions.

Healthcare record: all information in both paper and electronic formats relating to the care of a service user.

HealthStat: a databank of performance information from Irish public health services.

HIPE: Hospital In-Patient Enquiry.

Histopathology: the study of tissues in diagnosis of disease.

Histopathologist: A specialist in the area of histopathology.

HSE: Health Service Executive.

Infection control: the discipline and practice of preventing and controlling Healthcare Associated Infections and infectious diseases in a healthcare organisation.

Initial Assessment Unit: a unit located in conjunction with an emergency department where patients, post-registration and triage, are initially reviewed and assessed by a senior clinical decision maker in order to ascertain the most appropriate care pathway for a patient.

Inpatient: a patient who remains in hospital while receiving medical treatment.

Integrated care: healthcare services working together, both internally and externally, to ensure service users receive continuous and coordinated care.

IT: information technology.

Key performance indicator (KPI): specific and measurable elements of practice that can be used to assess quality and safety of care.

Laboratory medicine services: laboratory service in which tests are done on clinical specimens in order to get information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease.

Licensing: the mandatory process by which a governmental authority grants permission to a healthcare organisation to operate.

Locum: a healthcare professional, with the required competencies, who is employed to temporarily cover the duties of another healthcare professional who is on leave.

Medicine: the treatment of disease by nonsurgical means.

Methodology: a system of methods, rules and procedures used for the delivery of a project.

MEWS: Medical Early Warning Score.

Microbiology: the branch of biology that deals with micro-organisms and their effects on other living organisms.

Microbiologist: a specialist in microbiology.

Monitoring: systematic process of gathering information and tracking change over time. Monitoring provides a verification of progress towards achievement of objectives and goals.

Morbidity rate: refers to the incidence or the prevalence of a disease or medical condition in a given population.

Mortality rate: refers to the measure of the number of deaths in a given population.

MRI: Magnetic Resonance Imaging.

MTS: Manchester Triage System

Multidisciplinary: an approach to the planning of treatment and the delivery of care for a service user by a team of healthcare professionals who work together to provide integrated care.

Musculoskeletal Physiotherapy: physiotherapy that deals with all conditions involving the mechanics of the body systems from muscle strains, ligament strains and tears, arthritic problems, tendonitis and muscle pains.

NCHD: non-consultant hospital doctor.

NEMP: National Emergency Medicine Programme.

Nephrology: the branch of medicine that deals with the kidneys, especially their functions or diseases.

Neurology: the branch of medicine that deals with the anatomy, functions, and organic disorders of nerves and the nervous system.

Non- Executive Board Member: a member of the board of an organisation who does not form part of the executive management team, nor are they an employee of the organisation.

Nurse Pre-assessment: a nurse-led service with the aim of reducing the number of patient cancellations for surgery through a pre-assessment of a patient prior to surgery to ensure that they are fit and suitable for the surgery. In addition to the pre-assessment, the patient is also provided with information on the intended surgery, details and requirements of their hospital stay, health promotion and plans for discharge.

Nutrition and dietetics: a service through which dieticians and nutritionists provide specialist advice on diet for patients in both hospital wards and attending outpatient clinics.

Occupational therapy: therapy based on engagement in meaningful activities of daily life, especially to enable or encourage participation in such activities in spite of impairments or limitations in physical or mental functions.

Oncology: the branch of medicine that deals with tumors, including study of their development, diagnosis, treatment, and prevention.

Outpatient department (OPD): a hospital department which is primarily designed to enable consultants and members of their teams to see patients at clinics for scheduled care. Patients attending the outpatient may be a new patient referral or patients who are attending for review following discharge from hospital or had previously attending the OPD.

Ophthalmology: the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

Orthopaedics: the branch of medicine that deals with the prevention or correction of injuries or disorders of the skeletal system and associated muscles, joints and ligaments.

Out of hours: outside the core working hours (9am-5pm, Monday to Friday).

PACS: Picture Archiving and Communication System.

Paediatrics: the branch of medicine concerned with the treatment of infants and children.

Palliative care: the specialised care of people with life-limiting illness.

Patient flow (flow of patients): patient flow is the movement of patients who seek care in a healthcare facility, from point of entry to the hospital to discharge.

Patient safety incident / event: an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. Patient safety incidents include an incident which reached the patient and caused harm (adverse event); an incident which did not reach the patient (near miss); and an incident which reached the patient, but resulted in no discernable harm to the patient (no harm event).

PCT: primary care teams.

Person-centred care: the behaviours, practices and protocols which ensure that the patient is at the centre of the delivery of coordinated and integrated care which, in turn, should ensure the best possible outcomes for the patient in terms of health and welfare.

Performance management/performance monitoring: process which includes activities that ensure that goals are consistently being met in an effective and efficient manner. Performance management can for example focus on the performance of an organisation, a department, service, or the processes to deliver a service.

Peri-operative: care that is given before, during and after surgery.

Pharmacy service: service for the preparation and dispensing of medicinal drugs.

Physiotherapy: a treatment of injury or dysfunction with exercises, massage and other modalities.

Pneumonia: an inflammation of the lung, usually caused by infection.

Podiatry: the branch of medicine that deals with the diagnosis, treatment, and prevention of diseases of the human foot.

Policy: a written operational statement of intent which helps staff make appropriate

decisions and take actions, consistent with the aims of the service provider, and in the best interests of service users.

Pre-assessment: pre-operative assessment establishes that the patient is fully informed and wishes to undergo the procedure. It ensures that the patient is fit for the surgery and anaesthetic. It minimises the risk of late cancellations by ensuring that all essential resources and discharge requirements are identified.

Primary care: an approach to care that includes a range of services designed to keep people well. These services range from promotion of health and screening for disease, to assessment, diagnosis, treatment and rehabilitation as well as personal social services.

Principle diagnosis: the medical condition that is the primary reason for a patient's admission to the hospital.

Protected disclosure: any communication made in good faith that discloses or demonstrates an intention to disclose information that may provide evidence of improper conduct which poses a significant risk to public health or safety.

Psychiatry: the branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders.

Pulmonary embolus: blockage of the pulmonary artery by foreign matter or by a blood clot.

Quaternary: quaternary care can be used to describe an extension of tertiary care in reference to medicine of advanced levels which are highly specialized and not widely accessed. Experimental medicine and some types of uncommon diagnostic or surgical procedures are considered quaternary care. These services are usually only offered in a limited number of hospitals.

Quality assurance: the systematic process of checking to see whether a product or service is consistently meeting a desired level of quality.

Radiation oncology: cancer treatment that uses high-energy electromagnetic radiation such as X-rays to kill cancer cells. During radiotherapy, a significant amount of healthy normal tissue is sometimes irradiated. To reduce the side effects caused by this, the radiation dose is often split into a number of treatments, enabling the normal healthy tissue to recover before the next treatment is given.

Radiology: the branch of medicine that deals with the use of radioactive substances in the diagnosis and treatment of disease by means of both ionizing (e.g. X-rays) and non-ionizing (e.g. ultrasound) radiation.

Rapid Access Stroke Prevention Service: a rapid access service for patients referred with suspected Transient Ischaemic Attack (TIA).

Regulation: a principle, rule, or law designed to control or govern conduct.

Rehabilitation Medicine: the branch of medicine concerned with the restoration of form and function after injury or illness.

Respiratory Medicine: the branch of medicine that deals with diseases of the respiratory system.

Rheumatology: the study of disorders characterized by inflammation, degeneration of connective tissue, and related structures of the body. These disorders are sometimes collectively referred to as rheumatism.

Risk: the likelihood of an adverse event or outcome.

Risk management: the systematic identification, evaluation and management of risk. It is a continuous process with the aim of reducing risk to an organisation and individuals.

Risk register: a risk register is a risk management tool. It acts as a central repository for all risks identified by an organisation and, for each risk, includes information such as risk probability, impact, controls and risk owner.

Scheduled care: describes the care which patients receive on a planned basis.

SACU: short acute stay unit.

SDU: Special Delivery Unit.

Secondary Care: secondary care is the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example acute hospitals.

Service: anywhere health or social care is provided. Examples include but are not limited to: acute hospitals, community hospitals, district hospitals, health centres, dental clinics, GP surgeries, home care, etc..

Service provider: any person, organisation, or part of an organisation delivering healthcare services [as described in the Health Act 2007 Section 8(1)(b)(i)–(ii)].

Service user: the term service user includes: people who use healthcare services (this does not include service providers who use other services on behalf of their patients and service users, such as GPs commissioning hospital laboratory services); parents, guardians, carers and family and potential users of healthcare services. The term service user is used in general throughout this document, but occasionally the term patient is used where it is more appropriate.

Skill mix: the combination of competencies including skills needed in the workforce to accomplish the specific tasks or perform the given functions required for safe high quality care.

Service Level Agreement (SLA) (Service Arrangements): a framework for the provision of services, including details of quality and governance requirements.

SOP: standard operating procedure.

Speech and Language Therapy: speech and language therapy is concerned with treating voice, speech, language, or swallowing disorders.

SpR: specialist registrar.

Stakeholder: a person, group or organisation that affects or can be affected by the actions of, or has an interest in, the services provided.

STARSweb: a national database established and maintained by the Clinical Indemnity Scheme of the State Claims Agency to record adverse clinical incidents and 'near misses' reported by hospitals.

Stroke: occurs when a blood vessel, carrying oxygen and nutrients to the brain, bursts or is blocked by a clot, causing an interruption of the blood supply to part of the brain

Surgical oncology: the branch of surgery which focuses on the surgical management of cancer.

Syncope and collapse: fainting with loss of consciousness.

Systems of care: frameworks within which healthcare is provided, comprising healthcare professionals; patients; resources, organisational and political contexts or frameworks; and processes or procedures.

TEDT: total time in Emergency Department.

Terms of reference: a set of terms that describe the purpose and structure of a project, committee or meeting.

Tertiary: tertiary care is specialized consultative healthcare, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary level hospital.

The Authority: the Health Information and Quality Authority.

Therapeutic care: care delivered to treat an illness or to improve a person's health, rather than to prevent an illness.

Tissue viability management: the prevention and management of all aspects of the skin and soft tissue wounds.

Trauma orthopaedics: the branch of orthopaedics that deals with the correction of injuries or disorders of the skeletal system and associated muscles, joints and ligaments which have been caused by trauma i.e. serious injury or shock to the body, as from violence or an accident.

Triage: the process in which patients are sorted according to their need for care. The kind of illness or injury, the severity of the problem, and the facilities available govern the process.

Ultrasound: a procedure in which high-energy sound waves are bounced off internal tissues or organs and make echoes. The echo patterns are shown on the screen of an ultrasound machine, forming a picture of body tissues called a sonogram.

Undifferentiated: all types of patients with any degree or seriousness or severity.

Unscheduled Care: unscheduled care is defined as care for people who require or who perceive the need for advice, care, treatment or diagnosis that is not planned or pre-booked, available everyday with a prompt response according to the urgency of the clinical need.

Ureteric calculus: kidney stone.

Ureteric colic: a sudden occurrence of pain due to abrupt obstruction of ureter from a calculus or blood clot in most instances.

Urodynamics: the diagnostic study of pressure in the bladder, in treating incontinence.

Urology: the medical and surgical specialty that involves the urinary tracts of males and females and the reproductive system of males.

Urinary Tract Infection (UTI): an infection of one or more structures in the urinary system.

Vascular surgery: surgery for the treatment of diseases of the vascular system – the network of vessels for the circulation of fluids throughout the body.

Videofluoroscopy Study of Swallow: recorded dynamic radiography that utilizes continuous X-rays to assess swallowing function.

Workforce: the people who work in, for or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or anyone who is responsible or accountable to the organisation when providing a service to the service user.

Wound management: a service for the management of wounds.

Appendices

Appendix 1

Investigation Team of Authorised Persons

Name	Role
Paddy Broe	Vice-President, Royal College of Surgeons in Ireland (RCSI) Consultant Surgeon and Clinical Director, Beaumont Hospital, Dublin
Mike Farrar	Chief Executive, UK National Health Service Confederation
John Heyworth	President of the UK College of Accident and Emergency Medicine Consultant in Emergency Medicine in Southampton General Hospital
Sheila O'Connor	National Coordinator, Patient Focus Patient and Lay Expert
Keith Pearson	Chairperson, UK National Health Service Confederation
Dermot Power	Consultant in Acute Medicine and Elderly Care, Mater Misericordiae Hospital, Dublin
Jim Wardrope	Past-President of the UK College of Accident and Emergency Medicine Consultant in Accident and Emergency Medicine in Northern General Hospital, Sheffield
Hilary Coates	Investigation Lead, Health Information and Quality Authority
Mary Dunnion	Investigation Deputy Lead, Health Information and Quality Authority
Margaret Cahill	Investigation Quality Manager, Health Information and Quality Authority

Appendix 2

Membership of the Advisory Panel

Advisory Panel		
Postgraduate Training Body	Name	Role
Royal College of Surgeons in Ireland (RCSI) Lead for Emergency Medicine	Una Geary	Consultant in Emergency Medicine in St James's Hospital, Dublin HSE National Emergency Medicine Programme Lead
Royal College of Surgeons in Ireland (RCSI) Lead for Orthopaedic and Trauma Surgery	John O'Byrne	Consultant Orthopaedic Surgeon, Cappagh National Orthopaedic Hospital, Dublin
Royal College of Physicians of Ireland (RCPI)	Diarmuid O'Shea	Consultant Physician and Elderly Care, St Vincent's University Hospital, Dublin HSE National Elderly Care Programme Lead
Irish College of General Practitioners (ICGP) Head of Quality and Standards	Margaret O'Riordan	General Practitioner, Co Tipperary
Nursing Advisor	Kathleen MacLellan	Former Head of Professional Development with the National Council for the Professional Development of Nursing and Midwifery Currently working in the Department of Health

Appendix 3

Request for data

AMNCH activity data

- Outpatient appointments and attendances (OPD)
- Adult elective and non-elective inpatient discharges
- Average Length of stay
- Bed occupancy rate
- Delayed discharges
- Theatre utilisation data
- Day case activity
- Inpatient discharges
- Emergency Department (ED) activity data
- ED attendances
- Waiting times to be seen by a senior clinical decision maker
- Waiting times to admission to inpatient bed
- Unplanned re-attendances
- Occupancy rate in the ED clinical observation unit
- Workforce – Emergency Department (ED), clinical observation unit and Corridor area adjacent to the ED data
- Emergency medicine consultants
- Non-consultant hospital doctors (NCHDs)
- Nursing staff
- Allied health professionals
- Healthcare assistants
- Administrative staff
- Diagnostic Imaging (DiagIm) – outpatient and inpatient workload data
- Adult inpatient and outpatient diagnostic imaging tests/procedures
- Adult Emergency Department diagnostic imaging tests/procedures
- Adult inpatient diagnostic imaging tests/procedures waiting times
- Adult Emergency Department diagnostic imaging tests/procedures waiting times

- Adult outpatient consultant prescribed diagnostic imaging tests/procedures waiting times
- Adult outpatient general practitioner prescribed diagnostic imaging tests/procedures waiting times
- Report turnaround time for adult inpatient diagnostic imaging tests/procedures
- Report turnaround time for Adult Emergency Department imaging tests/procedures
- Report turnaround time for adult outpatient consultant prescribed diagnostic imaging tests/procedures
- Report turnaround time for adult outpatient general practitioner prescribed diagnostic imaging tests/procedures
- Adult elective diagnostic imaging test/procedures data – outside of core hours
- Adult emergency department diagnostic imaging test / procedures data – on-call hours

HSE Dublin Mid Leinster

- HSE budget allocation and expenditure data (AMNCH)
- HSE non-capital budget allocation and expenditure data (AMNCH)
- HSE pay expenditure data (AMNCH)
- HSE non-pay expenditure data (AMNCH)
- HSE capital budget allocation and expenditure data (AMNCH)
- Human resources data (AMNCH)
- Elective inpatient discharges data (AMNCH)
- Day case discharges data (AMNCH)
- Emergency presentations data (AMNCH)
- Emergency attendances data (AMNCH)
- ED waiting times data (AMNCH)
- ED admissions data (AMNCH)
- AMNCH catchment area data (AMNCH)
- Primary care data (AMNCH)

HSE National

- HSE Dublin Mid Leinster and Dublin North East catchment area data
- Primary care team data (DML and DNE)
- HSE National – Emergency Department activity data
- Emergency Department (ED) attendances and acute admissions for the 24-hour period from 09:00 on 23 August 2011 to 08:59 on 24 August 2011
- ED – registration to triage waiting time data
- ED – clinical assessment waiting time data
- ED – outcome, admission, discharge data
- Hospital data
- Inpatient bed availability data
- Reported adverse incidents, complaints, INMO disclaimer data

Appendix 4

Request for documentation

AMNCH Hospital Board

Governance structure

- Copy of the "the charter" as it is referred to in the "THE ADELAIDE HOSPITAL (CHARTER AMENDMENT) ORDER, 1980" as "the Letters Patent of the 27th day of November, 1920, granting incorporation to the Adelaide Hospital, Dublin".
- List of membership of the current AMNCH Hospital Board, to include ex officio members.
- Scheme of Delegation and sub-delegation from the AMNCH Hospital Board to the Executive.
- Copy of the code of ethics/conduct for Directors/members of the AMNCH Hospital Board, including disclosure of Directors'/Board members' interests.
- List of the AMNCH Hospital Board Subcommittees in place and corresponding reports submitted to the Board, as of September 2011.
- Copy of the description of the roles, accountabilities and responsibilities of all members of the AMNCH Hospital Board.
- Copy of the criteria, including competencies, skills and knowledge, used to select all members of the AMNCH Hospital Board.
- Outline of training provided to new members of the AMNCH Hospital Board and any ongoing training/development for all members of the AMNCH Hospital Board for the years 2010 and 2011 to present.
- List of members co-opted to the AMNCH Hospital Board for 2010 and 2011 to date, to include reason for co-option and the criteria used for selection plus remuneration.
- Copy of the job description and performance objectives of the officers of the AMNCH Hospital Board 2010 and 2011 to present.
- Copy of the scheme of delegation for approval of expenditure limits, AMNCH, for 2009 and 2010.
- Copy of the annual audited accounts (financial statements), AMNCH, for 2009 and 2010.

Committees and meetings

- Dates and minutes of meetings where conflicts of interests have been declared by Directors/members of the AMNCH Hospital Board for the years 2010-2011 and a copy of the Register of Interests for the years 2010-2011.
- List of decisions requiring the authority of the Chair of the AMNCH Hospital Board, outside formal Board meetings to include date and time of decision and subsequent actions for the years 2010-2011.
- Terms of reference for all sub-committees of the AMNCH Hospital Board, to include names of chairs and members.
- Terms of reference and membership of the AMNCH Hospital Board Subcommittees in place as of September 2011.
- Dates, agenda, minutes of special or extraordinary meetings of the AMNCH Hospital Board, to include attendance and non-attendance for 2010 and 2011 to present.
- Records of attendance and non-attendance at the meetings of AMNCH Hospital Board for each meeting for 2010 and 2011 to present.
- Copy of minutes of the meeting of the AMNCH Hospital Board meeting of September 2011.
- Copy of the Terms of reference, membership, schedule and minutes of meetings of the Audit subcommittee of the Board, from January 2009 to 2011 to date.
- Copy of the terms of reference, membership schedule and minutes of meetings of the Resources subcommittee of the Board from January 2009 to 2011 to date.
- Copy of the record of performance review meetings with the officers of the AMNCH Hospital Board for 2010 and 2011 to present.

Reports, strategies and action/implementation plans

- Agreed Strategy and Business Plans of the AMNCH Hospital Board from 2008-2011.
- Copy of the report/result of any audit of competencies, skills and knowledge of officers and members of the AMNCH Hospital Board.
- Copy of the review of consultancy fees (Draft or final) as referred to in minutes of the Audit Committee meeting held on Tuesday 20 September 2011 at 1.15pm in the NCH Boardroom, AMNCH.

Policies, procedures and guidance

- Copy of the policy or procedure for the remuneration of all members of the AMNCH Hospital Board, to include the procedure/decision making process for the agreement of remuneration for each year, 2010 and 2011 to present.

Correspondence

- Copies of any letters received by the Chair of the Hospital Board of the Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH), regarding concerns about the quality and safety of the provision of services by AMNCH for the years 2009-2011.
- Copies of correspondence from the Chair of the Hospital Board to the Foundations that pertain to the composition of the AMNCH Hospital Board and the Charter, from January 2009 to 2011 to date.
- Copy of the letters of correspondence from the previous Chair of the AMNCH Hospital Board to the President of the AMNCH Hospital Board for 2010 and 2011 to include the final copy of correspondence in relation to corporate governance reform.

Clinical Governance and Clinical Services

Clinical governance structure

- Organogram for clinical governance structure for the provision of adult ED services at AMNCH, demonstrating clear lines of accountability and reporting relationships to include 24-hour ED management and clinical cover arrangements.
- Organogram for the clinical governance structure for the provision of clinical services in the patient corridor adjacent to the ED at AMNCH.
- Terms of reference, membership, schedule and minutes of meetings for the
 - local adult ED clinical governance group/committee at AMNCH, since January 2011
 - the HSE ED Action Planning Group, of which AMNCH is a member, since January 2011.

Reports, strategies and action/implementation plans

- current Theatre Utilisation plan
- ED Turnaround plan for Q2 and July 2011
- ED Turnaround Plan Key Performance Indicator Trend Analysis Reports to include weekly KPI reports from Jan - June 2011
- 2011 Work Plan for the adult ED service at AMNCH (developed as part of the performance management framework)

- the specific clinical strategies developed by clinical specialties at AMNCH from January 2011 to date
- policies, procedures and guidance
- copy of any audits of the application and efficacy of the current triage classification system in use in the ED at AMNCH
- copy of current adult ED Escalation Policy
- current policy and/or guidelines for the adult ED triage classification system in use at AMNCH
- current operational guidelines for the clinical observation unit to include the clinical inclusion and exclusion criteria
- current operational guidelines for the patient corridor adjacent to the ED to include the clinical inclusion and exclusion criteria
- current Risk Register for the AMNCH ED
- clinical inclusion and exclusion criteria for patients allocated to the corridor adjacent to the ED
- current Bed Management Policy for AMNCH, to include admission and discharge processes
- current AMNCH inpatient and day case patient booking process /policy
- list of current system-wide clinical protocols in use at AMNCH
- list of current hospital-wide clinical care pathways in use at AMNCH
- copy of the policy for the transfer of clinical responsibility for patient care from the stage of clinical assessment in the ED at AMNCH, to the stage of clinical assessment by the relevant specialty hospital team and to the stage of admission to a hospital ward
- copy of the Standard Operating Procedure/Policy for Diagnostic Imaging in tests/procedures to include the prioritisation (urgent, soon, routine) of referral requests/prescriptions and report procedures, and any evaluations of the efficacy of this system.
- Standard Operating Procedure for the booking of OPD appointments and management of OPD non-attendances, and any evaluations of the efficacy of this system
- referral requirements/guidelines for Diagnostic Imaging tests/procedures prescribed
- copy of the arrangements/policy/procedures for performing and reporting of diagnostic imaging test/procedures outside of core hours at AMNCH to include on-call arrangements for cross-sectional imaging (by MRI, U/S and CT imaging), Plain Film and interventional procedures.

Service provision

- List of current diagnostic imaging tests and procedures provided at AMNCH for adult inpatients and outpatients.
- Hours of operation for routine diagnostic imaging tests and procedures to include schedule and details of out-of-hours service provided.
- List of third-party providers of diagnostic imaging test/procedures for adult inpatient and outpatients at AMNCH, to include diagnostic imaging tests/procedures provided and copies of the related service level agreements (SLA).
- Report of the outline of the current AMNCH Bed Designation with details of the overall total number of beds, number of adult and paediatric beds to include details of bed closures since January 2011.

Corporate Governance

Governance structures – AMNCH

- Organograms of the corporate and clinical governance structure of AMNCH demonstrating the interface between them, to include clear lines of accountability and reporting relationships in the hospital up to and including the AMNCH Hospital Board.
- Organogram to demonstrate the interface between the governance structure of AMNCH and the HSE Dublin Mid Leinster, demonstrating clear lines of accountability and reporting relationships in the hospital, up to and including the AMNCH Hospital Board and the HSE Dublin Mid Leinster.
- Copy of the organogram to reflect the proposed governance structure for AMNCH, as of September 2011.
- Copy of the proposed Code of Governance submitted to the AMNCH Hospital Board in September 2011.
- Job descriptions, to include roles and responsibilities, of the CEO, AMNCH (2010 and 2011), Lead Clinical Director and Clinical Directors (as of September 2011) and the Medical Director (prior to September 2011).
- Copy of the record of performance review meetings with the CEO, AMNCH for 2010 and 2011 to present.

Governance structures – HSE Dublin Mid Leinster

- Organogram to demonstrate the interface between the governance structure of AMNCH and the HSE Dublin Mid Leinster, demonstrating clear lines of accountability and reporting relationships in the hospital, up to and including the AMNCH Hospital Board and the HSE Dublin Mid Leinster.
- Details of the HSE delegation of functions from the RDO of the HSE Dublin Mid Leinster to the CEO of AMNCH.

Service level arrangements, agreements and contracts – AMNCH

- Copy of tender documentation and process for awarding the contract for the "Identification of significant risks to quality and the development of a governance and quality improvement plan for the Adelaide and Meath Hospital Dublin, Incorporating the National Children's Hospital" project, including copy of contract.
- Tender documentation and process for awarding the contract for the "Provision of Services to Assist Operational Turnaround the Adelaide and Meath Hospital Dublin, Incorporating the National Children's Hospital" project, to include copy of contract.

Service level arrangements, agreements and contracts – HSE DML

- Current service level agreements/arrangements with the Health Services Executive for the provision of services at AMNCH.

Service level arrangements, agreements and contracts – HSE National

- Details of the services provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) that are not in accordance with the detailed schedule under the Section 38 Service Level Agreement between the HSE and the Adelaide and Meath Hospital, incorporating the National Children's Hospital.
- Detailed schedule of the services provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) in accordance with the Section 38 Service Level Agreement between the HSE and the Adelaide and Meath Hospital, incorporating the National Children's Hospital.
- Guidance document and operating toolkit for the management and monitoring of the performance of all Voluntary Hospitals against the Service Level Agreement (SLA) between the Health Service Executive (HSE) and those Voluntary Hospitals, under Section 38 of the Health Act 2004, including the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital, (AMNCH).
- Copies of the completed Supplementary Support Information form and Governance Self Evaluation Questionnaire that accompanied any applications for funding made by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH), in accordance with Section 38 of the Health Act, 2004 for the years 2009, 2010 and 2011, in addition to any HSE evaluations thereof.

Committees/Directorates and meetings – AMNCH

- Terms of reference, membership, schedule and minutes of meetings from January 2011 to July 2011 of
 - the AMNCH Hospital Board
 - the Governance subcommittee of the AMNCH Board
 - the Transitional Board of Management of AMNCH
 - AMNCH and the HSE Dublin Mid Leinster
 - the Medical Board of AMNCH
 - the hospital Clinical Governance Committee of AMNCH
 - the hospital Risk Management Committee from
 - the Forum for Adverse Incident Review
 - the Clinical Audit Committee
 - the Quality and Governance Committee
 - the Resource Committee
 - the Audit Committee
 - the NCH Committee
 - the Nursing Committee
 - the Patient Forum of AMNCH
- Terms of reference, membership, agenda, minutes and schedule of meetings of Acute Governance Review Group for 2010 and 2011
- Terms of reference, membership, agenda, minutes and schedule of meetings of the Executive Management Team of AMNCH from January 2011 to July 2011
- Copy of Terms of Reference and membership of the GP Liaison Committee
- Schedule, agenda and minutes of meetings of the Perioperative Directorate, the Medical Directorate and the Diagnostic Directorate, AMNCH for the years 2010 and 2011
- List of other existing hospital committees responsible for the management of performance in relation to the quality and safety of clinical services at AMNCH
- Terms of reference, membership, schedule and minutes of meetings of the local adult ED clinical governance group/committee at AMNCH, since January 2011.
- Terms of reference, membership, schedule and minutes of meetings of the HSE ED Action Planning Group, of which AMNCH is a member, since January 2011.

Committees and meetings – HSE DML

- Terms of reference, membership, schedule and minutes of meetings of
 - AMNCH and the HSE Dublin Mid Leinster from July 2010 to July 2011 to monitor performance in relation to the implementation of service level agreements/arrangements with the Health Service Executive for the provision of services at AMNCH from January 2011 to July 2011
 - AMNCH and the HSE Dublin Mid Leinster in relation to the reconfiguration of acute hospital services within the HSE Dublin Mid Leinster, to include AMNCH from January 2011 to July 2011
 - AMNCH and the HSE Dublin Mid Leinster in relation to the implementation of the Hayes report from July 2010 to July 2011
 - AMNCH and the HSE Dublin Mid Leinster in relation to the management of adverse events, clinical incidents, complaints and compliments in the HSE Dublin Mid Leinster, to include AMNCH for July 2010 to July 2011
 - the regional risk committee for HSE Dublin Mid Leinster for 2010 and 2011

Meetings – HSE National

- Minutes (2010 - 2011) of the Risk Committee of the Board of the HSE that relate to the Adelaide and Meath Hospital, incorporating the National Children's Hospital.

Reports submitted to the AMNCH Hospital Board – AMNCH

- Copies of all papers/reports submitted to the Board of AMNCH from 1 January 2011 to present, to include:
 - CEO reports
 - AMNCH Hospital Board Clinical Governance Committee / Chairperson's reports
 - Adverse events, clinical incidents, risk reports and reviews
 - Copy of papers/reports/power point presentations, submitted to the AMNCH Hospital Board from January 2010 to present, by the Medical Director, AMNCH.
- Copies of the document attachments sent to AMNCH Hospital Board members by CEO designate, AMNCH, on 01 July 2010 in advance of the Hospital Board meeting on 05 July 2010.

Reports, strategies and action/implementation plans – AMNCH

- current AMNCH Hospital Code of Governance
- current AMNCH Corporate Strategy
- current Report "Setting a Strategic Direction for AMNCH"

- AMNCH Corporate Business Plan for 2010 and 2011
- AMNCH Annual Report for 2009 and 2010
- AMNCH Annual Reports for 2010 and 2011 as submitted by AMNCH to the Health Service Executive (HSE) in accordance with schedule 5 of the Section 38 Service Level Agreement between the HSE and the Adelaide and Meath Hospital, incorporating the National Children's Hospital
- current service level agreements with the Health Services Executive for the provision of services at AMNCH
- Human Resources Strategy
- staff engagement plan
- Service user Involvement Strategy for AMNCH
- Operational Turnaround Programme for AMNCH (as referenced in the Hayes report), to include most up to date programme status reports
- Governance and Quality Improvement Plan for AMNCH
- Implementation plan for the recommendations of the Review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH) - Hayes Report and Report of the diagnostic review (AMP) carried out on behalf of the HSE Quality and Patient Safety Directorate at AMNCH and action plan
- Acute Medicine Programme Implementation Plan
- the Nursing Instrument for Quality Assurance Bi-monthly results report
- reports of any external and internal reviews of the governance, management and provision of clinical services at AMNCH, carried out since January 2009
- report of the Acute Governance Review Group
- report of dashboard in use at AMNCH performance meetings, to include the twelve performance indicators
- report/outcome of the recent staff perception audit
- reports submitted to the Special Delivery Unit of the Department of Health, by AMNCH
- existing Business plan for AMNCH if different from the Business Plan of January 2011
- project plan for the development of the GP out of hours service, to include project team membership
- project plan for the development of the initial assessment unit, to include project team membership
- list and copy of current performance metrics required by and reported to the Health Services Executive.

Reports, strategies and action/implementation plans – HSE Dublin Mid Leinster

- implementation/action plan and status report, developed in response to review of performance (in line with HSE Performance Monitoring and Control) for the HSE Dublin Mid Leinster, to include AMNCH
- implementation/action plan developed in relation to the reconfiguration of cancer services within the HSE Dublin Mid Leinster, to include AMNCH
- primary care service implementation/action plan and status report for HSE Dublin Mid Leinster to include AMNCH and catchment area/population
- report demonstrating the GP out-of-hour arrangements for the AMNCH catchment area/population
- cumulative annual HealthStat Dashboard for AMNCH for the years 2009, 2010 and the six month period of January 2011 to June 2011
- copy of the regional HSE Risk Register for the Dublin Mid-Leinster region as it relates to the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH) for 2010 and 2011 to present.

Reports, strategies and action/implementation plans – HSE National

- most up-to-date vision or strategy for the provision of acute hospital services in the Dublin Mid Leinster and Dublin North East regions to include the Adelaide and Meath Hospital, incorporating the National Children's Hospital
- draft report of the review of catchment areas for the HSE Dublin Mid Leinster and Dublin North East regions
- action plan and status report for the implementation of the Integrated Service Areas (ISA) for the HSE Dublin Mid Leinster and Dublin North East by each catchment area
- the review and analysis of the allocation of resources (human and financial) throughout HSE Dublin Mid Leinster and Dublin North East, by each catchment area
- the primary care service implementation/action plan and status report for HSE Dublin Mid Leinster and Dublin North East for each catchment area demonstrating an alignment with the HSE vision/strategy for the area
- the National HSE Risk Register as it relates to the Adelaide and Meath Hospital, incorporating the National Children's Hospital
- the Integrated Services Directorate, Performance and Financial Management Whole Health System Approach to improving patient throughput/flow and Emergency Department Performance, 2010
- the report of the Health Service Executive's (HSE) audit of the implementation of the recommendations of the review of Radiology Reporting and the Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the National Children's Hospital, (AMNCH), (Hayes report)

- the reports of population health analyses/reviews carried out to inform the strategic direction for the provision of health services in Ireland, at national, regional and/or local level across the HSE from 2009-2011 to date
- status report of the implementation of the objectives of the HSE Clinical Care Programmes at AMNCH and nationally
- copy of the 2009 Teamwork Report (draft or otherwise) of Governance in Voluntary Hospitals
- copy of the report and HSE circular in relation to the definition of a closed bed

Policies, procedures and guidance – AMNCH

- copies of policies, procedures and guidance relating to
 - adverse events, clinical incidents, complaints and compliments and relevant quality improvement initiatives developed from January 2011 to June 2011
 - The verification of registration status with regulatory bodies
 - The maintenance of records of mandatory training and continuous professional development
 - The clinical criteria for the management of patients in the short stay Burkitt ward
 - The full capacity protocol in place at AMNCH, as of September 2011
 - The most recent Policy for Infection Prevention and Control to include patients in the ED
 - The Theatre Operational Policy to include details of core hours for each theatre, the Theatre Schedule for each operating theatre, management arrangements of elective theatre lists, management arrangements for emergency theatre service and adult and paediatric on-call arrangements
- list of existing policies, procedures and strategies and guidance pertaining to the management of performance in relation to the quality and safety of clinical services at AMNCH

Policies, procedures and guidance – HSE DML

- HSE policy or procedure for the review of performance of services in line with HSE Performance Monitoring and Control at regional level.

Information Systems – AMNCH

- list of Information systems currently in operation at AMNCH.

Appendix 5

HIQA letter to Chief Executive of the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital



STRICTLY PRIVATE AND CONFIDENTIAL

Eilish Hardiman
Chief Executive Officer
Adelaide and Meath Hospital incorporating the National Children's Hospital
Tallaght
Dublin 24

22 November 2011

Our ref: HQS\INV\456

Dear Eilish,

Investigation into the quality and safety of services & supporting arrangements provided to patients requiring acute admission and receiving care in the Emergency Department of the Adelaide & Meath Hospital incorporating the National Children's Hospital

As you are aware, the Health Information and Quality Authority (the Authority) is currently undertaking an investigation into the quality and safety of services at the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH), in accordance with section 9(1) of the Health Act 2007 and this work is ongoing.

In the course of the investigation, issues have been identified that the Authority believes may have the potential to pose serious risk to the health and welfare of persons requiring unscheduled acute care at AMNCH. Specifically, issues have been identified in relation to the

1. Clinical accountability and responsibility for the patient throughout the patient journey, from registration and triage in the Emergency Department to admission or discharge.

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There is specific concern in relation to the designated clinical accountability and responsibility for patients who have been referred to a specialist in-house team by an Emergency Department clinician, and in the interim period of a decision to admit or discharge. It was reported to the Investigation Team that a handover protocol has been introduced in relation to this. However, it was noted during the course of the Investigation that there was not a mutual understanding or acceptance of this protocol between clinicians.

Can you please confirm the arrangements in place to ensure that at all times there is a designated Consultant accountable for the care of every patient throughout their journey and details of how these are being monitored.

2. The availability of on-call in-house teams, specifically in relation to the availability of senior clinical decision makers.

Please confirm the roster arrangements currently in place to ensure the availability of on-call in-house teams to attend the Emergency Department, specifically in relation to the availability of senior clinical decision makers.

3. Sustainability of current interim measures taken to cease the use of the corridor adjacent to ED for patients awaiting admission.

Please provide details of the assurances and measures currently, and going forward, to ensure that patients awaiting admission shall be accommodated in an appropriate, safe environment relative to the needs of the patient.

Please provide the above, by return, no later than **Tuesday, 29 November 2011**.

If in the course of the Investigation, further potential serious issues relating to the health and welfare of patients receiving services at AMNCH are identified then these will be brought to your attention.

Yours sincerely,



HILARY COATES
Authorised Person

CC: Archdeacon David Pierpoint, Chairperson, AMNCH Board

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Appendix 6

Onsite observation form used by HIQA during unannounced inspection of the ED at the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital on 24 August 2011

Clinical Area:

Onsite Observation	
Project:	I5
Service Provider:	AMNCH
Clinical area:	Corridor adjacent to ED
Date:	24/08/2011
Authorised Person:	
HIQA Co-ordinator:	
Accompanied by SP Staff:	Yes/No (please indicate as appropriate)

Theme: Patient Centred Care		
It is recognised that short stay areas will not be identical in every respect to longer stay inpatient wards. However for patients in these short stay areas (i.e. corridor adjacent to the ED) to be treated AS ADMITTED , the environment needs to be such that the patient experience is similar to other inpatient wards.		(please indicate as appropriate)
		Yes/No
<i>The criteria below list the minimum criteria to be taken into account:</i>		
1	Privacy and dignity	
2	Access to toilet and washing facilities	
3	Number staff or public thoroughfare through the area	
4	Facility for patients to securely store their belongings	
5	Sufficient space between beds to allow visitors to be seated in comfort	
6	Provision of hot meals	
7	Appropriate levels of nursing and clinical cover	
8	Patients should recognise the ward as being different from ED	
Theme: Governance, Leadership and Management / Effective and Safe Care		
9	Does clinical area have an exclusion / inclusion policy?	
10	Is there a named Nurse Manager in charge?	
11	What Grade is the named Nurse Manager?	
12	Who is the named person accountable to?	
13	What are the nurse staffing/skillset arrangements for the corridor?	
14	Are patient rounds by senior clinical decision maker (reg/consult) structured?	
Non-invasive medical equipment / emergency equipment		
15	Is there piped oxygen?	
16	Is there bed head suction?	
17	Is there bed head cardiac monitoring?	
18	Is there easy access to emergency response equipment?	
19	Is there easy access to non invasive medical equipment (i.e. oxygen/suction/IV infusion pumps)	

Appendix 7

HIQA letter to Chief Executive of Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital



Eilish Hardiman
Chief Executive Officer
Adelaide and Meath Hospital incorporating the National Children's Hospital
Tallaght
Dublin 24

25 August 2011

HQS\INV\340

Dear Eilish,

Investigation (the "Investigation") into the quality, safety and governance of the care provided to patients who require acute admission into the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (the "Hospital").

As you are aware, the Health Information and Quality Authority (the "Authority") is currently undertaking an investigation into the quality, safety and governance of the care provided to patients who require acute admission at the Hospital in accordance with section 9(1) of the Health Act 2007 as amended (the "Act") and this work is ongoing.

As part of the investigation, and in accordance with section 73 of the Act, Authorised Persons carried out an unannounced inspection of the Emergency Department (the "ED") and adjacent corridor on 24 August 2011. A number of issues were identified by the authorised persons which the Authority believes may have the potential to pose serious risks to the health and welfare of persons receiving services at the Hospital.

While these issues and this correspondence will be referred to in the (draft) report of the Investigation on its conclusion, the Authority believes it is important that these issues are brought to your attention now, in advance of this. This is being done so that the issue may be addressed and managed by the Hospital as a matter of urgency.

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Patients admitted and awaiting transfer to an inpatient bed / facility

At the time of the unannounced inspection there were twenty patients who following a decision to admit, were awaiting transfer from the ED and adjacent corridor to an inpatient bed. The twenty patients were waiting transfer to an inpatient facility between 3 and 83 hours with five of these patients waiting greater than 24 hours since the decision to admit.

There were three patients being isolated in clinical rooms in the ED. In particular, one patient with a provisional diagnosis of tuberculosis had been accommodated for more than 72 hours in a clinical room. The said three clinical rooms were not isolation rooms, did not have appropriate isolation facilities and opened directly onto a corridor where other patients were being cared for. This posed a potential serious risk of cross infection to these patients.

Can you please review this and provide assurances to the Authority that these risks are mitigated and managed together with an explanation of the actions taken to mitigate and manage these risks.

At the time of the unannounced inspection in the opinion of the Authorised persons the majority of admitted patients on the corridor adjacent to the ED were not of a low acuity. In particular, two patients were waiting transfer to the ED Clinical Decision Unit, a third patient with a cardiac history had not at the time of the unannounced inspection been assessed or admitted by any in-house clinical team, therefore these three patients were outside the Hospital's inclusion and exclusion criteria.

These serious risks to patients, being cared for in the corridor adjacent to the ED while awaiting transfer to inpatient beds/facilities following a decision to admit identified during the unannounced inspection, are unacceptable. The Authority recommends that the use of the adjacent corridor to accommodate any patient is ceased as a matter of urgency and requests that you provide an implementation plan with timelines to cease use of the corridor adjacent to the ED by close of business on Thursday 01 September 2011.

In the meantime and in advance of cessation of the use of the adjacent corridor to accommodate any patient, can you please provide the Authority with assurances and explanations of what is proposed to mitigate and manage the immediate risks to patients by close of business on Monday 29 August 2011.

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In the course of the investigation, the Authority may carry out further unannounced inspections and any risks to the health and welfare of patients identified will be brought to your attention.

I would like to thank you and your staff for the information provided and the professionalism and courtesy extended to us during the inspection.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Hilary Coates".

Hilary Coates
Authorised Person

CC: Cathal Magee, Chief Executive, Health Service Executive
Michael Scanlan, Secretary General, Department of Health

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Appendix 8

Letter to HIQA from Chief Executive, Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital

THIS NOTEPAPER MUST NOT BE USED FOR
PRESCRIPTIONS OR INVOICING PURPOSES

OFFICE OF THE CHIEF EXECUTIVE OFFICER



THE ADELAIDE & MEATH
HOSPITAL, DUBLIN
INCORPORATING
THE NATIONAL CHILDREN'S HOSPITAL

29th August 11

Hilary Coates
Authorised Person
HIQA
Dublin Regional Office
George's Court
George's Lane
Dublin 7

TALLAGHT, DUBLIN 24, IRELAND
TELEPHONE +353 1 414 2845
FACSIMILE +353 1 414 2896



Re: Investigation into the quality, safety and governance of the care provided to patients who require acute admission into the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital.

Dear Hilary,

I acknowledge receipt of your letter dated 25th August 2011 outlining your findings from the unannounced visit to the Emergency Department at Tallaght Hospital on Wed 24th August 2011.

As you are aware I took up the post of Chief Executive on August 15th 2011. Firstly I wish to reiterate the willingness of Tallaght Hospital's leadership and management to fully co-operate with the HIQA Investigation. The provision of safer better care is one of my key objectives in taking up the post. Secondly this correspondence is to respond to the requests made in your site visit feedback letter and to bring to your attention some relevant factors.

Your letter outlines issues that the hospital needs to address as a matter of urgency. The Hospital endeavours to address all patient safety, risk and quality issues, within its control and the resources allocated to it and within the constraints of the Irish healthcare system.

Isolation Facilities

With reference to the isolation of potentially infectious patients and while the Hospital has a well established Infection Control policy and perceives the following factors need to be brought to the attention of HIQA in relation to this matter. Tallaght Hospital is a relatively recent build, considering the ageing state of acute hospitals in Ireland, but it was designed and built in an era that did not anticipate the need for a significant increase in single and isolation rooms to meet the isolation requirements currently experienced by all hospitals (both in Ireland and internationally) due to an existential increase in Healthcare Acquired Infections. The appropriate placement and isolation of infectious and potentially infectious patients is an everyday challenge faced by all hospital in Ireland. Of the total number of beds at Tallaght Hospital (634), there are 120 single rooms with en-suite facilities, 55 single rooms without en suite facilities and only 17 rooms +/- pressure rooms with no HEPA filtration. As in most healthcare systems, the daily demand for isolation facilities outstrips the supply of isolation rooms. Therefore, to best mitigate the risk of cross contamination the Hospital activates its Infection Prevention and Control Policy and can demonstrate the effective management of infection.

ED Processes

I can confirm that the Hospital is reviewing the process of the senior decision maker to both refer and admit patients attending the ED. The Board of Management have issued instruction that all patients in the Emergency Department are the responsibility of the Emergency Department Consultant until their care is accepted by the in-house admitting service and once the decision is made to admit the patient by a service, the patient care and responsibility is transferred to the admitting Consultant.

Low acuity patients awaiting access to a hospital beds are in accordance with the HSE Escalation Policy (Reference; Integrated Service Directorate, Performance and Financial Management Whole Health system approach to improving patient throughput/flow and Emergency Department Performance, Nov 2010), as agreed with in January 2011, and are moved from the ED to the in-patient wards for processing. These patients are the lower acuity patients in ED awaiting admission.

The Clinical Decision Unit in the ED is managed by the ED clinicians and is designed to effectively manage a specific cohort of patients using internationally recognised protocols. Patients who meet the admission criteria are best admitted and managed in this unit as their discharge is processed in a speedy manner due to the presence of senior-decision making clinicians managing their care according to protocols. It is the most appropriate placement for specific conditions, to effectively manage their care and subsequent discharge.

Corridor in ED

Adherence to the inclusion and exclusion criteria for placement of patients on the corridor in ED was initiated from 25th August 2011 for patients waiting for admission on the corridor within the ED. As and from Monday 29th Aug at 17.00hrs, the corridor in ED will no longer be used to place admitted patients waiting access to an inpatient bed.

Delayed Discharge

Since taking up my post, I have initiated a Taskforce with specific Action Teams to focus and engage clinicians and managers on promoting the discharge of appropriate patients and admission avoidance initiatives. I must point out the untenable situation where as an acute hospital, a significant number of in-patient beds are occupied by patients that no longer require acute hospital care but are waiting for placement in nursing homes or discharged home with Home Care Package support. The hospital does not control the placement of these patients into nursing homes; this functionality is undertaken through the Fair Deal Programme by the Department of Health and the allocation of funding for Home Care Packages is undertaken by the HSE. The hospital met with the HSE Management on Monday 29th to highlight the immediate need for allocation of Home Care Packages but due to financial constraints in the HSE, funding is not available to support these patients in the community. This hospital, in collaboration with the other DATHs, has continuously identified this capacity constraining situation to both the funding and policy making authorities.

Data Accuracy

In an effort to demonstrate our co-operation with the investigation process, all the requested data from your unannounced site visit was fully submitted in a timely manner. I want to ensure the accuracy of all data submitted. I can confirm that all standardised reports have been tested to ensure valid data outputs. I note that there were exceptional reports requested during the site visit, and while the data outputs were directly shared with you, these exceptional reports had to undergo validity testing after the site visit. I can confirm that the outputs of these tests validated that the data submitted was accurate. However, I would like to bring to your attention that the validity of exceptional reports requested on a site visit can only be assured post testing.

The safety of patients and quality of care is a high priority for the hospital. I would be most grateful if going forward, if any further data is required that all requests are sent to my office. We will endeavour to mitigate risks and provide quality care to the patient we serve but it must be acknowledged that we have to do this within the constraints of resources allocated to Tallaght Hospital.

Thank you for acknowledging the professionalism demonstrated by staff in their participation with the announced site visit to the Emergency Department.

I would be grateful if all future correspondence, including requests for data, come through the CEC office for data compilation purposes.

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,



ELISH HARDIMAN
CHIEF EXECUTIVE

C: Mr Michael Scanlon, Secretary General, Department of Health
Mr Cathal McGee, Chief Executive, HSE

Appendix 9

HIQA letter to Secretary General, Department of Health and Children



STRICTLY CONFIDENTIAL

Michael Scanlan
Secretary General
Department of Health and Children
Hawkins House
Dublin 2

1 February 2012

Ref: HQS\INV\538

Dear Michael,

Investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH), for patients who require acute admission.

As you will be aware, the Health Information and Quality Authority (the Authority) is currently undertaking an investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH), for patients who require acute admission.

During the course of any Investigation undertaken by the Authority, if having considered the evidence that is gathered, the Investigation Team identifies deficiencies in respect of services provided, these deficiencies are brought to the attention of the provider, or other relevant individual, at that time in order for them to be addressed and mitigated.

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As you will be aware, the investigation team undertook an unannounced inspection of the Emergency Department (ED) at AMNCH on the 24 August 2011. However, as we are aware, the challenges which exist in Ireland's EDs are not unique to the AMNCH alone and therefore, in order to gain an understanding of the national picture of EDs across Ireland on that same date, validated data was requested on the same day from 9am on 23 August 2011 to 8.59am on 24 August 2011, through the Health Service Executive (HSE) Corporate Office, for all statutory or voluntary hospitals (excluding AMNCH) providing emergency department services. Excel workbooks were provided for data collation and the data was requested only if available electronically.

The HSE coordinated the data submission for 33 hospitals providing various levels of emergency department services.

However, no hospital was able to fully complete the data request. 9 hospitals were unable to complete any part of the data request as data was unavailable electronically. In this instance, hospitals were requested to provide activity data for the number of ED attendances and number admitted for the defined 24 hour period. The remaining 24 hospitals provided data for time of registration, discharge and admission to an inpatient ward as well as the attendance outcome. Only 18 hospitals provided data for time of triage and only 14 hospitals provided data for time seen by ED clinician. Limited or no data was provided for time of referral to the speciality team and time of decision to admit.

It should be noted that a number of data integrity issues were identified when preparing the data for analysis, these included:

- Missing outcome data to complete waiting time calculations
- Incorrect date and time data format requiring reformatting to support analysis
- Inconsistency with outcome related data, for example, patient outcome identified as "admitted" with no date/time entered for time of admission to an inpatient ward, however date/time entered for time of discharge from ED. In this instance, assumption applied that the date/time related to time of admission to an inpatient ward or that the patient remained in ED until discharge.

Irrespective of the above, and whilst the data returned was not consistent in the level of detail provided by all 33 hospitals, the Authority is concerned as to the overall wait times recorded for patients pending admission or discharge. Any wait time from registration to admission or discharge, beyond six hours is linked to poor patient outcomes. The data reported by the HSE shows that patients attending the majority of EDs in Ireland experience waiting times of greater than

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six hours, with the longest waiting times including up to 115.49 hours for discharge and 137.48 hours for admission. (Appendix 1)

I am aware that progress in relation to the waiting times in the EDs is being made with the Special Delivery Unit's interventions and support to various hospitals across the system and, as a result, these findings may have changed since this information was collated. We would be happy to receive any updated, accurate information that demonstrates such change.

However, in view of the serious nature of these preliminary findings, not only in relation to the potential risks to patients associated with long waiting times in an ED but also the lack of data documented and/or available which suggests that the system of care is not being as actively managed as it should be, I am requesting that the Special Delivery Unit review and address these issues as a matter of priority.

In view of the fact that these preliminary findings have arisen from a statutory investigation, I would appreciate that the content of this correspondence is treated with the utmost confidentiality at this point given that the Investigation process is ongoing. These findings will be included in the report of the investigation.

Please feel free to contact me directly if you have any questions in relation to this correspondence.

Yours sincerely,



DR TRACEY COOPER
Chief Executive

CC: Cathal Magee, Chief Executive Officer, HSE
Tony O'Brien, Chief Operating Officer, DoH, Special Delivery Unit

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Appendix 1 of letter to Secretary General, Department of Health and Children – National ED attendances for 24-hour period from 09:00 on 23 August 2011 to 08:59 on 24 August 2011

ED Attendances Over view						
HSE Region	Hospital Group	Hospital	Total number of ED attendances	Number of ED attendances discharged from ED	Number of ED attendances admitted	ED admissions as a % of ED attendances
DML		AMNCH	117	84	33	28%
DML		Mullingar / MRHM	82	69	13	16%
DML		Naas	59	36	23	39%
DML		Portlaoise / MRHP	142	124	18	13%
DML		St Columcille's	34	15	19	56%
DML		St James's	134	98	36	27%
DML	SVUHG	St Michael's	40	38	2	5%
DML	SVUHG	St Vincent's	119	94	25	21%
DML		Tullamore / MRH	90	70	20	22%
DNE	CMHG	Cavan	85	66	19	22%
DNE	LMHG	Drogheda / OLLHD	158	115	43	27%
DNE	LMHG	Navan / OLHN	50	45	5	10%
DNE		Beaumont	150	113	37	25%
DNE		Connolly	191	152	39	20%
DNE		Mater	142	109	33	22%
South	CUHG	Bantry	9	6	3	33%
South	CUHG	CUH	166	110	56	34%
South	CUHG	Mallow	56	50	6	11%
South		Kerry	68	52	16	24%
South		Mercy	69	60	9	13%
South		South Infirmary Victoria UH	71	62	9	13%
South		South Tipperary	73	55	18	25%
South		St Luke's Kilkenny	61	54	7	11%
South		Waterford	169	135	34	20%
South		Wexford	86	61	25	29%
West	GUHG	Galway	174	157	17	10%
West	GUHG	Portiuncula	60	48	12	20%
West	MWRHG	Dooradoyle / MWRHL	154	112	42	27%
West	MWRHG	Ennis	36	27	9	25%
West	MWRHG	Nenagh	33	31	2	25%
West		Letterkenny	102	62	40	25%
West		Mayo	92	65	27	29%
West		Sligo	79	59	20	25%
West		St John's Limerick	59	50	9	15%

Appendix 1 of letter to Secretary General, Department of Health and Children – National ED attendances for 24-hour period from 09:00 on 23 August 2011 to 08:59 on 24 August 2011

ED attendances by Referral Source (Volume / %)							
Hospital	Self referrals		Other		GP Referrals		% of GP referrals admitted
	Vol.	%	Vol.	%	Vol.	%	
AMNCH	81	69%	16	14%	20	17%	N/A
Mullingar / MRHM	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Naas	30	51%	2	3%	27	46%	52%
Portlaoise / MRHP	79	56%	34	24%	29	20%	N/A
St Columcille's	N/A	N/A	N/A	N/A	N/A	N/A	N/A
St James's	81	60%	9	7%	44	33%	30%
St Michael's	30	75%	4	10%	6	15%	0%
St Vincent's	60	50%	31	26%	28	24%	25%
Tullamore / MRH	40	45%	1	1%	49	54%	20%
Cavan	47	55%	10	12%	28	33%	25%
Drogheda* / OLLHD	86	54%	16	10%	56	35%	25%
Navan / OLHN	32	64%	-	-	18	36%	N/A
Beaumont	80	53%	10	7%	60	40%	22%
Connolly	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mater	90	64%	16	11%	36	25%	11%
Bantry	1	11%	-	-	8	89%	38%
CUH	45	27%	25	15%	96	58%	32%
Mallow	22	39%	-	-	34	61%	12%
Kerry	36	53%	0		32	47%	25%
Mercy	40	58%	7	10%	22	32%	18%
South Infirmary Victoria UH	26	37%	31	44%	14	19%	29%
South Tipperary	45	62%	3	4%	25	34%	36%
St Luke's Kilkenny	32	52%	3	5%	26	43%	12%
Waterford	69	41%	27	22%	63	37%	29%
Wexford	69	80%	2	2%	15	18%	N/A
Galway	71	41%	3	2%	100	57%	10%
Portiuncula	17	28%	19	32%	24	40%	33%
Dooradoyle / MWRHL	N/A	N/A	74	48%	80	52%	26%
Ennis	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nenagh	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Letterkenny	42	41%	10	10%	50	49%	52%
Mayo	37	40%	2	2%	53	58%	28%
Sligo	33	42%	11	14%	35	44%	20%
St John's Limerick	30	51%	3	5%	26	44%	19%

Appendix 1 of letter to Secretary General, Department of Health and Children – National ED attendances for 24-hour period from 09:00 on 23 August 2011 to 08:59 on 24 August 2011

Timeliness of ED Admissions

Total Time in ED (TEDT) target: 95% within 6 hours / 100% within 9 hours of arrival in ED

Hospital	Median time from ED Registration to admission to ward (hh:mm)	Longest time from ED Registration to admission to ward (hh:mm)	95th Percentile (hh:mm)	Number admitted within 6 hours of ED attendance (time from ED registration to admission)	% admitted within 6 hours of ED attendance (Time from registration to admission)	Number of admitted patients who remained in ED until discharge	Number of admitted patients in ED greater than 24 hours (from time of Registration)
AMNCH	14:13	25:53	22:09	3	17%	N/A	1
Mullingar / MRHM	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Naas	15:24	66:47	65:33	2	9%	2	4
Portlaoise / MRHP	N/A	N/A	N/A	N/A	N/A	N/A	N/A
St Columcille's	N/A	N/A	N/A	N/A	N/A	N/A	N/A
St James's	8:51	24:54	18:39	7	19%	0	1
St Michael's	5:46	6:03	6:01	1	50%	0	0
St Vincent's	11:01	42:24	36:03	4	16%	1	7
Tullamore / MRH	6:52	25:56	24:08	9	45%	0	2
Cavan	20:23	25:52	25:47	5	25%	2	5
Drogheda / OLLHD	18:43	73:35	69:58	7	16%	7	14
Navan / OLHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Beaumont	16:27	40:52	39:37	5	14%	0	11
Connolly	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mater	19:15	38:32	33:04	2	6%	0	14
Bantry	1:30	7:22	6:46	2	67%	0	0
CUH	16:45	48:53	46:05	21	38%	0	13
Mallow	1:43	3:30	3:29	6	100%	0	0
Kerry	3:52	11:44	11:39	10	63%	0	0
Mercy	4:45	15:25	14:01	5	56%	0	0
South Infirmary Victoria UH	5:04	22:29	17:36	5	56%	0	0
South Tipperary	3:32	10:05	8:32	16	89%	0	0
St Luke's Kilkenny	5:50	10:25	10:24	4	57%	0	0
Waterford	9:53	19:54	19:29	8	24%	0	0
Wexford	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Galway	10:29	69:45	47:45	3	18%	9	2
Portiuncula	4:58	137:48	67:00	8	67%	0	1
Dooradoyle / MWRHL	10:08	26:41	24:26	16	38%	0	3
Ennis	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nenagh	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Letterkenny	6:55	20:16	11:59	17	45%	2	0
Mayo	4:10	11:01	7:18	23	85%	0	0
Sligo	N/A	N/A	N/A	N/A	N/A	N/A	N/A
St John's Limerick	6:08	7:53	7:25	3	33%	0	0

Appendix 1 of letter to Secretary General, Department of Health and Children – National ED attendances for 24-hour period from 09:00 on 23 August 2011 to 08:59 on 24 August 2011

Timeliness of ED attendances discharged directly from ED					
Total Time in ED (TEDT) target: 95% within 6 hours / 100% within 9 hours of arrival in ED					
Hospital	Median time from ED Registration to discharge from ED (hh:mm)	Longest time from ED Registration to discharge from ED (hh:mm)	95th Percentile (hh:mm)	Number of ED attendances discharged from ED within 6 hours of time of registration	% of ED attendances discharged from ED within 6 hours of time of registration
AMNCH	6:53	22:36	16:04	31	43%
Mullingar / MRHM	N/A	N/A	N/A	N/A	N/A
Naas	6:39	21:19	12:10	15	42%
Portlaoise / MRHP	N/A	N/A	N/A	N/A	N/A
St Columcille's	N/A	N/A	N/A	N/A	N/A
St James's	3:59	15:47	10:16	71	72%
St Michael's	1:03	4:53	3:41	38	100%
St Vincent's	3:20	24:39	10:44	76	81%
Tullamore / MRH	2:12	25:02	4:41	68	97%
Cavan	1:36	26:34	13:41	56	91%
Drogheda / OLLHD	2:42	75:51	20:59	87	77%
Navan / OLHN	N/A	N/A	N/A	N/A	N/A
Beaumont	5:45	28:26	20:20	63	56%
Connolly	N/A	N/A	N/A	N/A	N/A
Mater	2:30	50:11	15:13	80	73%
Bantry	1:05	2:45	2:23	6	100%
CUH	4:02	38:51	15:39	78	71%
Mallow	1:25	5:25	4:44	48	100%
Kerry	1:48	5:43	4:15	52	100%
Mercy	3:31	100:33	10:40	50	83%
South Infirmary Victoria UH	2:49	21:01	14:44	43	69%
South Tipperary	1:57	8:34	5:40	52	95%
St Luke's Kilkenny	3:11	8:25	5:03	46	98%
Waterford	2:49	24:13	8:37	86	90%
Wexford	N/A	N/A	N/A	N/A	N/A
Galway	5:38	91:52	26:41	82	52%
Portiuncula	2:31	6:39	4:36	44	98%
Dooradoyle / MWRHL	2:20	29:07	21:37	92	82%
Ennis	N/A	N/A	N/A	N/A	N/A
Nenagh	N/A	N/A	N/A	N/A	N/A
Letterkenny	2:39	12:38	7:54	41	91%
Mayo	2:42	115:49	43:05	59	91%
Sligo	N/A	N/A	N/A	N/A	N/A
St John's Limerick	2:35	7:45	4:36	48	96%

Appendix 10

HIQA letter to Minister for Health



STRICTLY PRIVATE AND CONFIDENTIAL

Dr. James Reilly T.D.
Minister for Health
Department of Health
Hawkins House
Dublin 2

18 November 2011

Ref: TC/KB/JR/181111

Dear Minister,

Investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission

The information gathering element of the Investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH), for patients who require acute admission is nearing conclusion.

During the course of any Investigation undertaken by the Health Information and Quality Authority, if having considered the evidence that is gathered the Investigation Team deem there to be serious, or potentially serious, risks to the health and/or welfare of a person receiving those services due to a failure in the governance, management or provision of services, these risks are brought to the attention of the provider, or other relevant individual, at that time in order for them to be addressed and mitigated.

The authorised members of the Investigation Team tasked with reviewing the governance arrangements in place at the Hospital, in accordance with Term 3 of the Terms of Reference for the Investigation, have reviewed the information

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received through our engagement with the Hospital including the documents and data provided by the Hospital and interviews that have been undertaken. Having considered the evidence to date, they have at this stage identified potential serious and urgent risks in relation to the lack of effectiveness of the Board governance arrangements in place at the Hospital and have brought these to my attention.

While these issues and this correspondence will likely be referred to in the (draft) report of the Investigation on its conclusion, due to the serious nature of the authorised persons' preliminary findings to date relating to the Board governance arrangements, the Authority believes it is important that these issues are brought to your attention now, in advance of this, in your capacity as Minister for Health and pursuant to the provisions of the Health Act 2007. This is being done to inform any changes being considered at this time.

In relation to the Board governance component of the investigation, all interviews have been completed and the final pieces of information sought will be received by the end of this week. The interview transcripts of the Board members interviewed are being issued and will be received, following factual accuracy checks, in two weeks time which should be the final stage of the synthesis of evidence for this component of the Investigation prior to a draft report being issued to interested parties.

In view of the serious nature of these preliminary findings, I am providing you with a summary of a number of emerging recommendations from the Investigation Team to date in relation to the Board of the Hospital. However, these may change prior to the finalising and publication of the report. Further recommendations may be made in relation to the Board and additional recommendations will be made in relation to corporate and clinical governance, the findings against the full Terms of Reference of the Investigation and also those that are relevant to national system-wide improvement. The preliminary recommendations are as follows:

1. In order to effectively lead, govern and stabilise the significant financial management and quality and safety challenges, and the deficits in governance and management that need to be addressed in the AMNCH, there is an urgent need to have an effective governing Board in place that is appointed independently and solely on the basis of competence and experience to effectively fulfil the role.

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2. The Board should consist of twelve persons (inclusive of the Chairperson) who are appointed through an independent process for Board appointments that is established by the State. In advance of such an independent process being established, the members of the Board should be appointed by the Minister for Health solely on the basis of such competence and experience as stated above. Individuals with conflicts of interest, including employees of the Hospital and those with other relevant conflicts of interest, should not be appointed to the Board.

3. If there are undue delays in constituting the Board as above, an interim arrangement should be put in place, as a matter of urgency, that ensures that individuals with the relevant non-Executive experience and competencies in organisational turnaround and strategic management, are formally incorporated into the membership of the Board with full voting rights and the necessary authority to lead the Board and support the Chief Executive in leading the organisation through the current challenges.

4. The AMNCH, with the support of the Minister and Department of Health, should establish an engagement mechanism through which the Foundations that have been actively involved in the management of the Hospital to date, can continue to engage with Hospital in a non-governing and non-managerial role and continue to inform and shape the future direction of the Hospital with the best interests of the public at heart.

In view of the fact that these preliminary findings having arisen from a statutory investigation, I would appreciate that the content of this correspondence is treated with the utmost confidentiality given that the Investigation process is ongoing.

Please feel free to contact me directly if you have any questions in relation to this correspondence.

Yours sincerely,



DR TRACEY COOPER
Chief Executive

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Appendix 11

HIQA letter to Office of Comptroller and Auditor General

John Buckley
Comptroller and Auditor General
Office of the Comptroller and Auditor General
Treasury Block
Lower Yard
Dublin Castle
Dublin 2



24 February 2012

Ref: TC/HC/JB/240212

Dear John,

Investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission (the Investigation)

Further to our recent discussion, as you may be aware, the Health Information and Quality Authority is currently undertaking a statutory investigation, in accordance with Section 9 of the Health Act 2007, into the quality, safety and governance of the care provided by the AMNCH for patients who require acute admission.

One of the terms of reference for the Investigation involves *"the assessment of the effectiveness of, and accountability for, the corporate and clinical governance arrangements in place within and between the Board, the Transitional Board and Executive of the AMNCH in addressing the quality and safety of services provided to patients in the Hospital"*.

During the course of the Investigation, detailed documentation and data have been reviewed by the investigation team (which consists of duly authorised persons), including minutes of Board and Board Committee meetings, specific documentation and policies and procedures. In addition, a variety of individuals have been interviewed including certain Board members, Executive team members, staff and patients.

The authorised persons on the investigation team have made me aware of what appear to me to be potentially serious concerns in relation to the lack of effectiveness of the governance arrangements in place at the Hospital. The Investigation is not a forensic assessment of the financial management of the

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Hospital and the members of the investigation team are not professionally qualified or experienced in this area. However, having considered the information which the investigation team has raised, I am of the view that the matters identified are potentially of serious concern. These matters are in relation to the:

- possible non-compliance with the Code of Practice for the Governance of State Bodies (Department of Finance, 2009)
- possible failure to comply with public procurement legislation, in particular in relation to procurement of services and commitment control
- effectiveness of the corporate governance arrangements including that of the Board and Board Committees (including the Audit Committee and Resource Committee)
- financial management and financial transparency
- relationship between funding and service provision
- Health Service Executive (HSE) budgetary and performance oversight of the AMNCH in accordance with the funding arrangements for the AMNCH by the HSE pursuant to Section 38 of the Health Act 2004 as amended.

The draft Report of the Investigation is currently being prepared and will be issued to interested parties for the purpose of their review and comment in the coming weeks and, following consideration of the feedback resulting from this process, the Report will be considered by the Board of the Authority for approval and it is envisaged that it will be finalised and published at that time.

While these issues and this correspondence may be referred to in the Report of the Investigation on its conclusion, due to the potentially serious nature of the matters raised above relating to these areas, the Authority believes it is important that these issues are brought to your attention now, in advance of this, in your capacity as the Comptroller and Auditor General and the relevant authority charged with investigating such matters.

I will be notifying the Chairperson and Chief Executive of the Hospital and the Chief Executive of the HSE of these concerns in due course.

Please feel free to contact me directly if you have any questions in relation to this correspondence.

Yours sincerely,



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Chief Executive

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Appendix 12

Board Competency Framework

	Competency	Rationale	Governance Outcomes
Knowledge			
K1	Knowledge of the Irish health system	Understands the environment that the hospital operates, the relationship with key stakeholders including the Department of Health, Health Service Executive, Health Information and Quality Authority. Understands community demographics and needs	Oversee and support building of strategic partnerships to achieve objectives. Ensure that the organisation does not operate in isolation of the national system for delivery of care. Support development with community organisation, primary and secondary care providers
K2	Knowledge of the Hospital and the executive management team	Understands the ethos, values, mission and strategy of the hospital. Understands the complexity of the organisation's challenges	Contribute to the vision and strategic direction for the organisation. Approve and monitor implementation of the strategy
K3	Knowledge of the legal and regulatory environment	Understands the Health (Amendment) Act 1996 (Accountability Legislation) and the Health (Amendment) Act 2005 and other relevant legislation including Health and Safety legislation, Taxation and Finance Acts, HR Legislation, Companies Act, Data Protection Act, Freedom of Information, and Public Procurement	Oversee compliance with legal and regulatory requirements
K4	Knowledge of corporate and clinical governance	Knows the difference between governance and management. Understands the fiduciary role of directors	Act as directors of a hospital board and not representative of any group. Monitors the executive's performance and holds the executive management team to account but does not cross into the management role. Oversee and monitor the management of corporate and clinical risks
K5	Knowledge of quality and patient safety processes	Understands quality and safety methodologies	Oversee the quality and safety improvement efforts and practices to improve patient experience and access

Skills: Analytical and Technical

S1	Performance oversight	Understands the dashboard of information and metrics required to oversee key quality and safety outcomes for patients	Provide assurances to the public that the service is providing sustainable safe, effective person-centred care. Board has access to the relevant information to support governance objectives. Approves and monitors hospital's compliance with the Section 38 agreement.
S2	Financial Acumen	Understands the economics of health care and the plan and budgets required to achieve the organisation's mission. Can read and interpret financial reports	Oversee and monitor financial performance to ensure organisation is operating within its funding allocation. Review and approve operating, capital and strategic budget. Provide assurances to the public that the service is managing its resources effectively

Skills: Attitudes and personal characteristics

S3	Improvement focused	Considers information and follows a logical sequence to make decisions	Board decisions are based on information that identifies opportunities for improvement and learning. Board structures and processes are consistent with best practice
S4	Open-minded, independent thinking	Considers diverse opinion and maintains own values and opinions despite opposition and influence.	Decisions are reached that consider all director's views and values
S5	Effective communication	Gives and receives information clearly	Board decisions are based on reasoned debate and contributions of members
S6	Integrity	Trustworthy and conscientious and acts openly and honestly	Board acts in the best interest of patients and service users. Board members declares any real or perceived conflicts of interests. Processes are in place to deal with conflicts of interest
S7	Effective judgement	Applies logical, risk based decision making	Risks are continuously prioritised and monitored. Clear schemes of delegation of authority are in place
S8	Orientation to negotiation and conflict resolution	Ensures that conflicts are resolved through negotiation	Accepts that the board has the authority and that individual board members have none. Board makes effective decisions based on reasoned open debate. Conflicts are resolved to ensure that focus is achieving hospital mission

Appendix 13

AMNCH Update

Since the commencement of the Investigation the Hospital reported to the Authority the following improvements in relation to governance leadership, executive management and clinical leadership to ensure safe high quality care for patients. These changes, as reported by the Hospital on 26 April 2011, are unvalidated by the Authority and are outlined below.

1 Hospital Board Structure and Composition

The Interim Board was established on 21 December 2011 with 9 non-executive directors including the Chairman and 7 executive directors including the Chief Executive. A Board Secretary has been appointed with the remit to ensure the Interim Board operates within legal and ethical parameters, including all good governance regulations required by publically funded bodies.

2 Board Style, Efficiency and Effectiveness

The Interim Board functions as a unitary Board and as a whole are accountable for the Hospital's management, operations, patient safety and financial stewardship. Agendas and minutes are published on the Hospital's website since February 2012.

3 Board monitoring of quality and safety of care provided to patients

Quality, Safety and Risk Management is a standing item on the Board agenda, with monthly reports including risks on the Risk Register presented by the Executive.

4 Board Committees

The Interim Board has revised and updated its committee structure which are chaired by non-executive directors, supported by the relevant executive directors, and are given clear remits and reporting arrangements agreed and approved by the Interim Board. The committee structure and roles includes:

Audit Committee

This Committee has the remit of ensuring strong financial governance in the hospital. The Interim Board has agreed to procure External Auditors through the procurement process.

Quality, Safety and Risk Management Committee

The Clinical Governance Committee has been replaced with the Quality, Safety and Risk Management Committee which has a clear remit to seek assurances of the executive on the implementation of the Quality, Safety and Risk Management (QSRM) Programme for the Hospital.

Remuneration and Terms of Service Committee

This Committee has a clear remit to oversee the implementation of the executive management structure and performance and make decisions on remuneration matters that require a formal approved process in accordance with employment policy/guidance.

5 Executive Management Structure and Composition

A new Organisational Management Structure was developed in September 2011 to ensure clear and unambiguous responsibility, authority and commensurate accountability across the organisation.

There are three functions to the Executive Management structure:

- Corporate function – Finance, HR, ICT, Corporate Affairs
- Service function – Four Clinical Directorates, Operations, Non-Clinical Support Services
- Quality, Safety and Risk and Professional Standards Function

6 Executive Role and Responsibilities

The Interim Board has a Scheme of Delegation to ensure there is clarity on the Board's remits and the executive managements' remits. This also ensures there is clarity between the role and remit of the Interim Board Chair and the Chief Executive. The corporate functions of Nursing, Quality, Safety and Risk Management, Finance and HR have changed to support the Clinical Directorates and the four Clinical Directors are now members of the Executive Management Team since September 2011.

These changes are currently at different stages of progression as follows:

- The **Director of Nursing** is the professional head of nursing in the Hospital and has the corporate remit for Patient Advocacy and Engagement.
- A new **Director of Finance** was appointed in January 2012.

- The post of **Medical Director** was changed to the **Director of Quality, Safety and Risk Management** (QSRM) in February 2012. The Director of QSRM leads on the QSRM Programme which covers all risks, with clear articulation of the executive manager responsibility for identified risk management streams or projects within the QSRM Programme
- The proposed Chief Operating Officer post is at the planning stage. This post will have the remit for the operational management of services in coordination with the Clinical Directors.

7 **Executive monitoring of quality and safety of care provided to patients**

The **Quality, Safety and Risk Management Programme** was established in December 2011 under the Chief Executive and responsibility for the programme was transferred to the Director of Quality, Safety and Risk Management in February 2012. The QSRM Programme has developed a performance framework which is used to track any follow up QSRM related recommendations, activities and actions that have been assigned to other Directorates/Departments including recommendations emanating from serious clinical incident reviews. A QSRM Charter has been developed to help define the vision, objectives and key work areas for the QSRM Programme in 2012.

8 **Focus on Hospital initiatives**

■ **Patients waiting on trolleys in ED**

There has been a significant reduction in the numbers and length of time patients in ED are on trolleys, whether admitted or not. The Hospital remains committed to eliminating the need to have any patient on a trolley with a target to have no patients waiting on trolleys after July 2012.

■ **Bed Management and Discharge Planning**

Significant emphasis on Discharge Planning has taken place with initiatives, such as, Home before 11 am, an increase in Discharge Lounge usage, Discharge Planners assigned to clinical areas, Transition Beds secured and funded for Long-term Care Patients, Increased Rehabilitation beds in the community, Expected Date of Discharge Project, closer collaboration with Peamount Healthcare, structured information flow and a more rapid response to bed capacity and demand pressures.

- **HSE National Clinical Care Programmes**

The Hospital launched the HSE National Clinical Programmes in late 2011 and early 2012. The key programmes with the largest impact on capacity and demand management that have commenced are: Acute Medical, Elective Surgery, Emergency Medicine, Heart Efficiency, COPD, Stroke, Rheumatology, with the Care of Older Persons just approved in April 2012.

- **Out-of-Hours GP Service**

The Hospital has collaborated very well with its local GP group who have opened an Out-of-Hours GP service in the Hospital's OPD since 1 November, 2011.

- **Inpatient and Day Case Patient Waiting Lists**

The Hospital also achieved the national Service Delivery Unit (SDU) waiting list targets set by the Minister, with no in-patient or day-case patient waiting greater than 12 months at the end of December 2011 and more importantly no waiting greater than 9 months in April 2012.

- **Hospital Financial Savings Plan**

The Interim Board has mandated the executive to plan and execute a challenging and detailed savings plan over two years. The Interim Board takes responsibility to review, approve and monitor the implementation of a savings plan and receives monthly updates on the plan and financial position of the hospital by the executive.

- **Review of Financial Governance**

In January 2012 the Interim Board and its Audit Committee commissioned an external review of the process for the granting and monitoring of Consultancy Contracts in 2010. The Interim Board is progressing with advice taken on the final report before it is shared with the Comptroller and Auditor General, HIQA and the HSE.

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